
*School Nursing in the
Community Program*

School Nursing in the Community Program

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TO

Mary Sewall Gardner

Who, through her understanding of children's health needs and her ability to apply public health nursing principles to school situations, did so much to secure effective nursing service for children

Foreword

The extent to which a community should develop special public health nursing for schools has long been a subject of debate between many school and health authorities and between public health nurses working within and without the school system. Some of the conflicts relate to jurisdiction and others stem from differences in judgment as to the wisest utilization of the time and skill of nurses in terms of priority needs in a given community. These questions will eventually resolve themselves within the groups raising them as personalities change and, more important, as new directions for health are clearly defined.

Health programs are expanding from communicable disease control and environmental sanitation to health protection through education for improved individual health. We hear, read, and talk about health promotion and growth and development and social interaction. How best can the social institutions like the home, school, health department, and hospital interact in planning a constructive health program to protect the health of a community? Is the school a natural center through which to reach the children of a community and their parents? Miss Swanson answers, yes, to the last question, and her book gives a wealth of information to shed light on the first.

That a program designed to help the development and protection of the child meets with public approbation is testified to by the steady growth of community public health programs specifically designed to safeguard children. Such programs encompass family health supervision, promotion of good health, prevention of illness, and provision of nursing care for the sick. Miss Swanson defines these purposes as those of a school nurse, stating that the "unique-

ness of the services of a public health nurse in and for the school lies not in what she does but how she does it."

How has school nursing developed? Just how does a school nurse conduct her work? What are the responsibilities of the school administrator; of the teacher; of the family? What are the relationships of the school to other social institutions in a community? What are the methods through which the nurse works with the school administrator, with teachers, with patients, with the family doctor, with children, with other community health and welfare agencies? What characteristics make an effective school nurse?

These and many more considerations comprise essential knowledge for all persons whose teamwork is essential if a balanced health program for school children is to be developed. This is a book about school nursing but obviously is not written with school nurses as the single target readership. The nurse in the school is in the position of a catalyst. She initiates and coordinates activities within the school and is the liaison officer between home, community agency, and school. Her success depends upon her skill in working with rather than doing for parents, children, community.

Tracing the evolutionary process of school nursing and describing a modern type service, Miss Swanson provides a measuring rod against which a school administrator, a health officer, or a community can evaluate the era of practice which the school program represents. Are the activities of the school nurse geared to "saving the doctor's time"; "to controlling communicable disease of which the major one might be one of skin or scalp"? Is the nurse a lone worker unable to give leadership to her team? Is the program tailor-made to the needs of the particular school, community, and finally to each child as an individual?

This book will give answers to these and many other questions important to public health nurses and especially to those who work in schools. More important though, it provides a long overdue discussion of what-for, how-to-do of school nursing, a knowledge of which is essential to health officers, school administrators, teachers, and enlightened citizens who would know the results of the community's investment in school health. The book is written in con-

siderable detail but of necessity so, since it deals with responsibilities shared by several categories of personnel. It provides a good reference for information about school nursing in general or as a textbook for students of public health administration, school administration, teaching, and of public health nursing.

Miss Swanson's long experience in teaching and in school nursing is discernible in the breadth of understanding and the thoroughness with which she has handled her subject.

MARION W. SHEAHAN
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National League for Nursing

Introduction

This book deals with the school child, his parents and teachers, the health department and other official and voluntary agencies, the community in which he lives, and the nurse who works in his school. It portrays nursing as it is most effectively carried on in the schools today. In the half century of its existence, school nursing has developed many patterns of operation, but the aims and objectives of the nurses doing the work have remained remarkably consistent. They have been established in situations surprisingly different from one another, some administered by the schools themselves and some by health departments and other agencies.

Although the discussion, of necessity, revolves around the nurse and her activities, the situation in which she works is seen as centered around the child and his family. The parents and family physician are observed to be of more vital importance to the health and development of the school child than are the school and health department. The nurse is seen as one of a team of professional workers, who may be official or nonofficial. This team includes as a minimum the teacher, nurse, and physician (family physician, school physician, health officer, or other). In some situations the team is expanded to include medical specialists of all kinds—sanitarians, social workers, and numberless others. The school is seen as an official agency which, like the health department and the welfare service, is responsible for certain specified services to the child and, like them, again has a concern with everything which touches the child, directly or indirectly.

The aims which the nurses have had as to what they should accomplish for school children have often differed widely from those advocated for them by others interested in educational and health programs. In the early days, the school physician saw the

nurse as his assistant in finding the children who should not be allowed to associate with other children and in taking them out of school. Even then, the nurse saw as her more important function working with the parents of these children to bring them back into school. As physicians extended their school work to include a search for defects that should be corrected, they utilized the nurse in examination and testing procedures and in the clerical work of notifying parents of defects needing treatment. The nurse saw the further need to explain to parents the necessity for treatment and in some instances to assist them in securing it.

The health officer valued the nurse's assistance in wholesale immunization of children in the school. She saw as more important her work with their parents at home to get them to seek immunization for their very young children.

In the early days nutritionists used her to conduct nutrition classes in the schools and to keep weight records to show gains made by the children. The nurse saw the value of going into their homes to show parents how to feed their children better.

Through the years other special interest groups have sought to utilize the nurse's services to develop their special programs in the schools. At different times and in different parts of the country, the nurse has been urged to get special supplementary training so that she could combine other programs with her own. Included have been such activities as classroom health teaching, classroom physical education teaching, sex education, teaching special corrective exercises to individuals, dental hygiene, audiometry, orthoptics, social service, attendance work, and general guidance and counseling. Such combinations were, and sometimes still are, urged when the nurse is the only professional worker in the school who is not a classroom teacher. Then these arrangements seem to offer the best possibility for the immediate implementation of the special program or service. Later as full-time workers trained in the specialty become available, these groups may become concerned that the nurse "stay in her own field."

In 1902, the nurse saw her role as most valuable when she served as adviser to children, parents, teachers, and school administrators

on health matters in those areas where her nurse's preparation and experience have given her special skill and information. Fifty years later, it is this same advisory service which the nurse still sees as her most important contribution to school health work. Her opinion to this effect is expressed in statements of function issued by nurses through their professional organization.

Since experts devoting full time to one phase of child health or psychology find it difficult to keep abreast of new developments in their own fields, how difficult then for a parent, teacher, or administrator to keep up to date. They need to know the general principles of growth and development applicable to all children and also the innumerable individual variations, some of which apply to only one child in a hundred, others to one in a thousand, and some to one in ten thousand. The nurse can be the practical agent bringing to the people who work with children help in recognizing when special information is needed; she then gives assistance in obtaining it.

Recognition of the value of the nurse's work in the school is increasing with the growing importance of pupil personnel services in general. These services, organized to study individual pupils, learn their special needs, and work out ways to meet them, making increasing use of the nurse's knowledge of children, their problems, and their families. The nurse as a key member of the school team functions in liaison with the school staff, parents, and other community agencies.

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*The Community's Part in the
Development and Protection
of Children*

A Community Program for Children

The family and family physician. Efforts of community agencies, such as the school and health department, to help in the development and protection of children are recognized to be of greatest value when directed toward strengthening and reinforcing the parents and family in their fundamental functions in this role. The nurse's work with and for children is most effective when used to this end. Health services for school children and for children of all ages, in and out of school, by the school and by the health department are seen to contribute most when used to strengthen and supplement, rather than to replace, those of the family physician.

In every community there are some individuals, officials, organizations, or agencies concerned with the health, happiness, welfare, or education of children. These may include official agencies, as those of health, education, welfare, and labor; and voluntary organizations as agencies for health, welfare, religion, recreation, and character building. In some communities representatives of various groups have met together, formally or informally, to study what is being done and what needs to be done, and to devise better ways of working together. They plan a community program for children and their families that will coordinate present activities and supplement them with additional needed services—the goal, a community program which will produce conditions in which children may best grow and develop.

for the child while he attends upon instruction. But unless the health department ensures a safe water supply, the school's provision of hygienic drinking fountains and of careful supervision to secure their hygienic use is nullified. The school's expenditures for a proper heating and ventilating system may be wasted if the parent insists on his child being overdressed as he sits in the classroom or cannot afford to provide proper clothing for his out-of-door activities.

The family may do its best to protect the health of its child by consulting the family physician whenever the child shows signs of illness and at proper intervals for anticipatory guidance, and may conscientiously follow his advice. But the child is not adequately protected unless the school gives this child and his schoolmates necessary health supervision while they are under the school's direction. Also essential is the health department's effective supervision of community health. Even then, the best efforts of the individual parent may prove insufficient to protect his own child unless efforts of parents who cannot or will not give their children health services needed in the home are supplemented by health or welfare authorities.

Parents and the school. It is well recognized that parents can do much to obtain the kind of schools they want in their community; it is not so well recognized that schools can do some things to develop the kinds of families needed by children so they will be able to get the most from their school.

Some schools are doing this through bringing parents in earlier to help in the planning when the needs of their own child are being planned for; other schools go a step further and are bringing groups of parents in to help in planning to meet general needs of all pupils.

Some schools, in addition to carrying on parent education programs of their own, are participating in other types of parent education; in those of the International Council of Religious Education or of Catholic or Jewish groups. These schools are working on parent education projects of the National Congress of Parents and Teachers, of the American Association of University Women, of the General Federation of Women's Clubs, and are using materials pre-

pared for this work by such parent education organizations as The Child Study Association of America and by government agencies—the Children's Bureau and The Home Economics Education Service of the Office of Education of the Federal Security Agency and of the Cooperative Education Service of the United States Department of Agriculture.

Individual schools of a school system cooperate with the families and groups in its area to improve neighborhood conditions so they will contribute most to the healthy physical and personality development of the children. They may carry on in their own organization education for family living adapted to the various age levels of their pupils, culminating in most high schools in a definite course or unit dealing with family relationships and personal development.

A smaller proportion of schools offer "in-service" education for parents paralleling the progress of their child through the school.

The school and the health department. Since the school has some health functions and the health department has some educational functions and since they are both working with the same group of people, it is evident that the more intensively these two basic community organizations work together, the more satisfactory it is for them and for the public they serve.

If in a certain community the health department is still in a developmental stage, the school as an organization and its personnel as individuals can well work to support and reinforce its efforts to obtain a budget and organization, facilities and personnel adequate for efficient functioning. Its efficient functioning is essential if the school is to have opportunity to educate the children of the community effectively. Not only are its services to school age children the school's concern, but those for the children before they come to school, in their infant and preschool periods. Of even greater importance is prenatal and maternity service. For certain of the children, an indirect protection is given through the health department's industrial health program and tuberculosis and venereal disease services for adults in the family group.

Other community factors. Economic conditions have great influence on the physical health of children through their direct

effect on family income and on the adequacy of community provisions for children as well. In addition variations in the incomes of families within the community affect personality development in contributing to class differences.

Prejudice and discrimination based on racial, ethnic, or religious group membership may affect not only health of personality but indirectly physical health as well through limitation of health services to special groups.

Religion can function as one of the prime integrative forces in family life and therefore in the child's life. It can give a child faith in God, in his family, and in himself; it can give him a needed "sense of belonging" and a chance for responsible participation in activities of accepted value.

Social services sufficient to protect the child, when the protection from parents is inadequate, and to give this in such a way that the family's self-esteem and that of the child are not damaged, are another essential in the community if all children are to be enabled to get full benefit from the educational opportunities the school offers.

Good housing, proper play space and recreational facilities adapted to different age levels are among the other essentials, which children must have and for which the school is not able by itself to provide.

Some communities may not have reached this stage of jointness in thought and action but a few individual participants in the work for children see the lacks in child services and are impelled to approach other persons or groups in the community in the attempt to secure new, improved, or increased programs. A parent may get a hot lunch program started in the school. A school superintendent may work for a county health unit. A nurse may ask the dental society for a reduced payment plan for selected families. A social worker may stimulate a service club to develop a children's recreational program. The tuberculosis association may place a demonstration dental hygienist in the school, or the parent-teacher association may work with the health department on an immunization program for infants and preschool children. In still other com-

munities, each individual or group may continue to work alone on a particular interest.

But whether or not a community consciously plans a program designed to influence the growth and development of children in desired directions, activities are always going on which influence the happiness, health, welfare, and education of the children who live in the community.

Although in a certain area no organized program of health education may have been established, children and their parents are bombarded daily by special pleaders, commercial and otherwise, who want to influence health attitudes, practices, and individual "knowledge." Parents' health training of children in more cases than not is a composite of their memory and interpretation of their own upbringing, what they hear on the radio, their impressions from the movies, and what they think their neighbors are doing.

Parental indifference to positive health considerations may affect the health of the children and at the same time inculcate in them a similar don't-care attitude. The school which emphasizes scholastic attainment at the expense of good mental, physical, and social health practices damages pupil health while it teaches subordination of health factors to specious accomplishments which can be canceled out unless supported by health. A health department which bases its budget and activities largely on mortality and morbidity rates at the expense of community health education and preventive measures teaches individuals to save their money to spend for care of illness rather than to spend it to maintain health.

Commercial recreational facilities teach children to depend on passive entertainment instead of developing interests and skills in creative activities and active participation in sports.

Public health nursing in a community program for children. The public health nurse is generally accepted as carrying the vital role in implementing any public health program. It is therefore intended here to tell how she functions rather than why.

There is no better place to practice public health nursing aimed at the organized improvement and protection of child health than through a school. Nowhere are there better opportunities for direct

access both to parents and to children. The very directness of this relationship enables the nurse to put emphasis on working "with" rather than "for" them.

Kilander's study ^{(2) *} of health services in schools of communities of 2500 population and over showed that nurses were used by a greater proportion of the 3186 school systems reporting than were other health service personnel. Nurses were used in 85.4 per cent of the schools, physicians in 62.9 per cent, dentists in 40.4 per cent, dental hygienists in 15.9 per cent, "other" in 11.7 per cent; and in 9.4 per cent of the schools no health personnel were available.

The extent to which nurses were available varied, by regions, from 99.1 per cent in New England and 97.6 per cent in Middle Atlantic to 62.4 per cent in West South Central and 72.3 per cent in West North Central. By city size, the range is from 100 per cent for cities of 100,000 and over to 80.4 per cent for the cities of the smallest size, 2500 to 9999.

A cursory review of the statements issued by the agency in each state responsible for the school health work gives the impression of great variety. They are put out by different agencies—education department, ^(2, 3) health department, ^(4, 5) joint committee; ^(6, 7) some are presented as separate publications relating only to the nurse's program; ^(3, 4) some are incorporated in a presentation of the work of all health personnel of the health department or school organization; ^(6, 8) some are printed while others are mimeographed; some are broken up in parts and printed serially in a general department publication ⁽³⁾ or perhaps in a special news letter to nurses doing school work. The publications vary in length from a few pages to several hundred.

The impression of confusion is intensified further by the fact that the approach is generally through description of activities; rarely is there even an attempt to define the term "school nursing."

Analysis of the programs presented, however, reveals that behind the apparent diversities of activities there is a very general agreement on the fundamentals of the service the nurse is to give. They

* The superior numbers within parentheses refer to references at the end of the particular chapter.

are found to be based on the common assumption that school nursing is the work a public health nurse does to improve community health, utilizing the organization, personnel, and facilities of the school to discover and meet the needs of children and to teach individuals and groups.

Greatest variation is observed in the amount of individual counseling planned for the nurse to give pupils and parents directly.

A unique school service. The uniqueness of the services of a public health nurse in and for a school lies not in what she does but in how she does it.

There is no function which is hers alone, she carries no responsibility in which others do not share. Superintendent and principal share her function as liaison between school and home and between school and community. Every teacher, principal, and parent share with her the responsibility for health guidance. Each school employee—administrator, teacher, and member of the maintenance staff share responsibility for safe and hygienic conditions in the building and on the grounds. The nurse's value to the school children and to the school organization is in direct proportion to her ability to bring to each of these activities a particularized understanding, scientific knowledge, skill, and effectiveness which is pointedly different from that of other school officers and of parents.

Effectiveness of the nurse's service. As liaison officer between the school and home, her success is dependent upon the depth of her knowledge of the individual pupil—his personality, his particular problems, the home from which he comes—and her knowledge of the school situation of which the child is a part. Her ability is influenced also by her understanding of the causes and effects of specific situations and problems, and by her skill in interpreting such causes and effects to parents, school staff, and pupils.

In her position as liaison between school and community, not only are such factors important, but essential also are her familiarity with community resources and broad understanding of the philosophy, purpose, and function of each community organization including the school itself. Her value in direct health guidance given pupils is likewise dependent upon her intimate knowledge

of them, their homes, and the community. She must know child health standards, scientific reasons for variations from them, fundamentals of nutrition, rest and exercise, and of mental, emotional, and social health.

The nurse's awareness of unsafe and unhygienic conditions in homes and schools is valuable but must be supplemented by scientific and practical knowledge of lighting, heating, ventilation, and sanitary provisions, and particularly the hygienic use of all facilities.

What the nurse may know of the children, their health needs, their parents and homes, will depend upon the intimacy of her association with them. Her knowledge of causes and effects, her scientific background, and her knowledge of general principles, on the other hand, are dependent on her professional preparation. For the new information in these areas which is constantly developing, she is dependent upon a continuous, well-planned, in-service educational program.

It follows that a nurse with superior preparation but with very little time to see and know the children, their school, their activities, and their teachers will be hampered in serving them, even if she is familiar with their homes through carrying out other community programs. Different hampering influences will handicap the nurse who may spend enough time in the school to know the school and the children but who lacks knowledge of the children's parents and homes.

Most undesirable of all may be the situation of the nurse who has ample time for health services in both the home and the school but who lacks the special preparation required to make a public health nurse out of a nurse prepared primarily for care of the sick.

Effectiveness, then, of the service a certain nurse gives in and through a school is determined not only by her own personality and professional preparation, but by the program in which she is working and the opportunity it gives her to know the children, the lives they lead, and the people who influence them.⁽⁹⁾

The purpose of school nursing. The final result of school nursing work, when effectively carried on, is the same as that of other successful types of public health nursing. It shares the objec-

tives for which all public health nursing services are designed—family health supervision, promotion of good health, prevention of illness, and provision of nursing care for the sick.

School nursing is not a specialty in the sense that orthopedics, tuberculosis, maternity, and venereal disease nursing are specialties; problems in all these fields may be encountered by a school nurse. Specialization in school nursing lies in its limitation to a certain age group of individuals through whom it makes its original entrance into the family. The approach to the family is through a school child instead of through the family's need for bedside care or the existence of a reportable communicable disease, or contact with a worker in industry. In working with the child, the nurse in the school must work with his family and with the community no less and sometimes more than in other public health nursing services. So although her public health nursing classification is that of a specialist, the school sees her as she functions within it, as very much of a generalist.

The nurse who elects school nursing may have a greater interest and preference for working with children of a particular age. Because of her intensive work in the school and with school age children she soon may have a greater knowledge of educational policies and procedures than do other public health nurses whose preservice professional preparation may have been identical. The differences in points of view which sometimes develop between such a nurse and other public health nurses are found to be related to methods and procedures, rather than to aims and objectives.

In no other field of practice does a public health nurse reach a wider range of the various social, economic, and educational groups of people that make up the general public. In none is there a clearer emphasis on health activities. Seldom is a more effective approach to family health supervision offered. The fourth aspect, provision of nursing care, if considered in the narrow connotation of clinical procedures for bedside care of the sick, takes a minor place and is characteristically limited to teaching such procedures to a member of the household or referral to another community agency for such care.

limits) in a manner he desires. The service of the public health nurse which comes to him through the school is looked upon from the same point of view.

The emphasis of the health program in the school is in the most obvious way upon health, and not upon illness. It is designed and easily understood as an instrument to help parents protect their children and secure for them a maximum development of health, efficiency, and happiness.¹⁰¹ While the family is and must always be considered responsible for the health of its members, life has become so complicated that few families, even of adequate financial ability, have sufficient recent scientific knowledge and familiarity with community facilities to carry the responsibility entirely alone. Some consultant service for making plans, and for securing information as a basis for making desirable choices among the multitude of possibilities open, is needed. A public health nurse with whom the family is already acquainted is a natural and reliable resource of such help.

The nurse's place in the traditional book-centered school. The principal of this school may see as the nurse's most valuable functions those directed toward securing a more regular attendance of the pupil—so that he is there to be taught—and those improving his ability to learn. Such a school emphasizes the removal of conditions which might lower his efficiency in studying, such as poor vision or hearing, fatigue, toothache, indigestion, or hunger. The child may then be a more successful scholar than he would be without the nurse's services.

The nurse's place in the child-centered school. The principal of this school appreciates the services described above for the same reasons, but he has a further motive. He appreciates the contributions such services make to the child as an individual, not just as a scholar in his school. He wants the nurse to help the child in his efforts to make himself socially acceptable to his group. This requires her to go beyond activities bearing directly on physical health improvement. She helps the child and his family understand the standards of clothing and hygiene practiced by the group and when necessary she helps child and parent in meeting them. She realizes and helps the family to perceive that variation from group

practice may cause the child to be ostracized. Early histories of delinquent children have revealed too often a feeling of exclusion from the group because of lice, communicable skin conditions, or dirty clothing.

Styles of clothing too far above those of the group may also be a hazard to a child's acceptance by other children. Appearing in the formalized clothing the well-dressed boy wears in an English public school might be as detrimental to his standing in one group as dirty clothes would be in another.

The nurse's place in the life-centered-community school. The principal of this school wants all the services which have been described. He also appreciates what the nurse may do to improve group standards in addition to helping individuals avoid personal damage through nonconformity to them.

It would be the first mentioned principal who might complain: "We've had more pupils excluded for illness this year since we have had a nurse than we did last year without one, and we had more cases of mumps this year in spite of having had a nurse than we did two previous years with no nurse." In such a situation, the second principal might add: "So, isn't it fortunate that since this is the year with such an unusual amount of nonpreventable illness we have had a nurse to help take care of the children who became ill in school and to instruct their parents about their care at home?"

The principal of the life-centered-community school would rejoice in the nurse's use of these experiences to help the children and their parents learn to protect others against their diseases (and want to do this), and to recognize and assume their own responsibility for self-care and protection of others in the family. He wants to see his nurse call to the attention of community health authorities possible sources of the spread of the infection. He would value any aid the nurse might give to the community's program for protection of preschool children from infections. As new measures become available he encourages her use of school facilities to carry out plans for community action to reduce epidemics previously considered nonpreventable.

As a community leader, this principal helps the nurse teach the

people that the cost of protection, in the long run, is less not only to individuals and families affected, but also to the public treasury, than the cost of neglect.

The nurse's place in any school. Seldom does a school fall exactly into any one of the three categories mentioned. A school is often a combination of two or even of all three. The nurse must look in each school for whatever ways she can find to attain the objectives which are the particular responsibility of school health service, through whatever channels the school offers. These objectives have climbed steadily and are continuing to climb.

One illustration of progress can be given from the field called environmental health. In the early days of school health services this was characterized by such a simple and concrete activity as that of fumigating a classroom in which a child had sat who later developed a communicable disease.

Our present concept of environmental health requires that the school health service personnel participate with other school personnel, parents, and workers of various community agencies in what is now regarded as a prime necessity in the healthy development of any child—his learning to live harmoniously in his ever-changing total environment. This is added to the earlier responsibility of guaranteeing a physical setting for school activities which is safe. Now, a mere absence of hazards is only the beginning; the setting must be developed in such a way that children are stimulated to seek and follow positive health practices.⁽¹¹⁾

Health service staff members as much if not more than other school personnel must accept the obligation to assist each child establish his potential relationships with other members of his community as his world begins to extend beyond his immediate home and family. The nurse especially sees opportunities to broaden his outlook. She helps him find a sound sense of duty toward his own family during those years when he is beginning to get a perspective on it and on his position in it, as that position is changing from time to time.

Through his "associates" in school—the health service staff—he may see and occasionally pattern after those who take the responsi-

bility of helping individuals or even the community as a whole secure things they need for health, happiness, or efficiency. This may contribute to his idea of an active constructive citizenship.⁽¹²⁾

In connection with health affairs in the school, more suitable circumstances arise than in most educational fields to allow a child to sense his state citizenship. The measures taken to protect him began to function before he was born and can be shown to continue from day to day.

While fewer in number and more remote from his personal experience, there are even national government activities by which he can be sensitized to his place as a national citizen: the protection given him by national labor laws to conserve his health, the many special provisions for children through such agencies as the Children's Bureau, the national school lunch program, and the Public Health Service.

To help him achieve his place as a world citizen, he can learn about the Junior Red Cross and the various children's projects sponsored by the World Health Organization, UNESCO, and other United Nation agencies, and by private philanthropies.

The nurse's objectives in school work today include those which the first nurse took with her when she went into the schools half a century ago, but they go far beyond them. The original purpose was to help remedy bad results from things which had already happened to the child. Now, while correction of defects is unfortunately still essential for many children, the nurse's additional and more constructive function is to help set the stage in the school, home, and community so that the child may grow and develop—physically, mentally, socially and emotionally—in the most healthy way possible. This is impossible for him unless all inhibiting factors are removed. Equally essential are positive and stimulating influences.⁽¹³⁾

Changing educational concepts which change the nurse's activities. In health education, the emphasis on textbook teaching has changed to an effort to see that the child lives healthfully while in school and develops desirable attitudes toward health. As a result some of the responsibilities for health supervision which

were originally assigned to the nurse have been transferred to the teacher, because of her continued contact with the child throughout the day.

The idea of fitting the school program to the child instead of the child to the school has resulted in requiring the nurse's participation in securing diagnostic and prognostic services for more pupils than was formerly the custom.

There has been an increasing realization that classroom teachers need to know a great deal about their pupils as individuals and about the families and homes from which they come. Formerly the teacher and nurse conferred mainly on "problem" children, but today the value of sharing information concerning each one of the pupils is recognized. Similarly, it has become evident that there is a value in tests of various kinds—physical, mental, and social—for all children, and not just for those showing difficulties. Physicians in their private offices and in clinics do a few tests on vision and hearing, but the proportion of children so reached is very small. The professional time required of the physician or his staff and the administrative problems involved in setting up such a service for all children has seemed too expensive for most communities even to consider it. Also, there is the hesitancy many parents feel in bringing apparently normal children for such tests. The nurse's part in planning, arranging for, and carrying out school testing programs varies from school to school, but her part in using the results for the benefit of each child and for seeing that his parent and teacher and perhaps his family physician receive pertinent information and explanation of the findings is a typical nursing function.

Younger children are being brought into the school in increasing numbers as nursery school and kindergarten facilities are extended. Children with greater variations from normal are being kept in regular classrooms instead of being assigned to special schools or even excluded from school entirely. Presence of younger children and those with severe handicaps dramatizes the need for intensive supervision and for careful protection against the dangers which threaten as these children participate in group activities. Boards

of education see the need for providing protection and guidance through increased nursing service as well as additional medical supervision. Parents feel greater confidence in turning their children over to the school when they know that a nurse visits it regularly.

As adolescents continue in school, they more and more seek information and guidance from the nurse, in whom they have learned in the elementary school to have confidence. Her health teaching to groups of these young people, informal as well as formal, is a tremendous contribution to a better informed adult public in the years following. For while community nursing service is fundamentally a nursing service to individuals and individual families, it has been found that service can be given more effectively and economically to them as they are part of an established social group. No person, even if he wishes to, can live entirely within himself and in no phase of his life is this more obviously illustrated than in regard to health matters.

Although many schools in this country, as well as in the rest of the world, are still without nursing service, and many of those which do have it possess it in inadequate amount, there is a general agreement on its desirability. The school which has once experienced competent nursing service, or in fact even an inferior variety, not only demands continuance of the service but more and more of it.

The nurse's part in making her place in the school. The nurse working in the school gives remarkably little service to the children or the staff which can be identified as "actual nursing"—the traditional care of the sick. But from the day of her first entrance into the school picture, administrators, teachers, parents, and even pupils have recognized her value because of the knowledge and judgment she has developed through her nursing education and professional experience. Her ability to recognize early deviations from normal, the reliability of her decision on whether a child is really sick, just temporarily uncomfortable, just thinks he is sick, or perhaps wants to think he is sick, her skill in persuading people—children, parents, and school personnel—that they wish to do what

they should do, her poise in handling an emergency, and her practical and specific information about health procedures and health hazards—all these things are universally recognized.

What the nurse is, because of her training and experience, has made a particular place for her in the school which is modern in its consideration of its own function. Such a school is concerned with improvement of community and social living; it feels it should function closely with other community agencies. Despite this, the Educational Policies Commission has said: "There are few schools which have built bridges over which people may freely pass back and forth between school and community." A nurse well informed and experienced in public health nursing, familiar with educational procedures and knowing the school and community, if allowed sufficient time for her school-community activities, is a potential builder of such bridges. In effective use of them, she is a helpful guide to pupils, parents, teachers, and other community workers, enabling the school to make best use of all community resources. She fosters increased utilization of school channels to further community projects, broadening the educational program.

School nursing as a community service. One sees certain points of similarity in the historical development of public health nursing in this country and that of our public school system. Each originated through the interest of citizens in various communities who wanted better conditions for people in the lower economic groups. In each case, the sponsors later extended the services to families of moderate means as well. Later still, each recognized that only through government support could necessary scope for a satisfactory program be obtained. These two services to the public now constitute a team designed to secure for all children that which the advanced pediatrician sees as the aim of his service to his private and clinic patients. He has assumed responsibility for a constructive health supervision of his patients, in addition to their care when ill. He realizes that if he is to protect the children from the tensions and emotional problems which they absorb from the fears and tensions of their parents, it must be through giving the parents an anticipatory guidance which will come to their aid

when they are faced constantly with new and unexpected situations as their own children grow and develop. In less complicated societies than ours, and even in our own in its earliest days, parents had a natural self-confidence in their ability to take care of their children and experienced enjoyment in doing it. As parents' fears and tensions are eliminated as they deal with their children, not only are the emotional problems of their children reduced but their physical ailments as well.

However, there is little prospect of enough pediatrician service to extend to all parents this anticipatory guidance. A possibility does exist for public health nursing and the school system of an interested community together to give valuable service along similar lines. It is more than a coincidence that during these past five decades while nurses have become more and more a part of the school system, parents too have been coming into the school. They have come singly and in group organizations, today as never before. The school is asking them to come and when they do not, the school is seeking ways to go to them. Through the public health nurse is one of the most effective ways that has been found for the school to go to the parent. It is during this same fifty years that the school has been gradually broadening its scope to function more intensively as a part of the community as a whole.

The school's educational processes are expanding to serve a wider public than merely the traditional school age group. The so-called "school age group" is at the same time being enlarged to extend upward through junior college and downward through the nursery school. In the health area it has extended its supervision beyond the school environs to youth employed under working papers. While in 1900, 2 out of every 10 children of ages 1-17 were out of school, by 1950 only 1 of every 10 of that group was out of school.⁽¹⁴⁾

All these modern developments reflect our American concept that a community should use every opportunity to help the individuals in it live more richly and to obtain the best life possible for everyone.

The nurse then in and through the school will participate in the community's program designed to equip parents to raise their chil-

children successfully and experience merited satisfactions in the process. She will play her part in family life by teaching in high schools. She will carry some of the responsibility for organizing and teaching classes for parents in the adult education program. She will serve as a liaison between parents and community resources for group instruction and individual counseling. She will engage continuously in self-education processes that will increase her ability to serve as a reliable consultant to parents in the many puzzling situations which confront them as they live their day-by-day lives with their children.

One of her special contributions will be to call these problems to the attention of the curriculum construction group so that more and more the idea of anticipatory guidance can be developed and potential parents can be prepared for the problems they will face in later years.

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Nursing in the School Health Program

Establishing the "school health program." For the present purpose it would make it easy if we could say: this is the school health program. It would then be possible to go on and in an orderly fashion point out the nurse's place in each part of it.

For the children concerned it would not be so desirable. Little observation is required to see that there is no one school health program. Not only must the over-all program be custom-made for each state, but within the state there must be adaptations for each community and within the community for each school. Even within the school each group of children has special needs for which the program must make provision, just as ultimately, the program must fit each individual child's needs. Despite needful variations, however, there is throughout the country general agreement on the basic features of the program, arrived at between the many professional and social groups concerned with children, in education, health, and social work. Medical, dental, nursing, educational, social work groups and representatives of citizen, parent and board of education organizations, hold a slow but growing recognition that the responsibility for health services for school children must be shared by agencies and individuals in all of these fields.

So while there is no neat diagram of "the school health program" on which can be plotted the nurse's part and her special activities, statements of principles are available regarding the building of a

proper health program. The statements have been developed by the various interested groups, each including the phase of service in which it has special interest. Thus a basis is furnished upon which any school, school system, or community can construct a program to meet its particular needs. Descriptions of typical programs as well as of desirable and minimal programs are available for comparative purposes. Estimates, unfortunately often too vague to give the practical help needed, have been made as to ratios of workers to pupils. State laws and local regulations have sometimes mandated certain requirements for the content of programs or ceilings on expenditures for them.

A local planning group, which may be limited to the school administrator, or a committee of the board of education, but on the other hand may be really representative of the community organizations, assumes the role of architect. Planners can do this with a certain degree of assurance for while they cannot secure a ready-made plan to be slavishly followed, they can take care that the steps taken are based on principles generally approved by authoritative groups.

The following definition of the nurse's role in the school health program is based on principles and policies established by interested professional and citizen organizations.

General aims and purposes. Of those which include lay points of view, the reports and recommendations of the periodic White House Conferences on Children and Youth held at intervals since 1909 have been perhaps the most forward looking and most inclusive.

The National Education Association and the American Medical Association have each approached the subject separately, but their most effective statements have come from their Joint Committee on Health Problems in Education. The American Academy of Pediatrics has made some valuable contributions. Nurses and lay people interested in nursing services expressed themselves formerly through the National Organization for Public Health Nursing and currently through the National League for Nursing. It is when a number of these groups have combined in setting up standards or program

outlines that the statements have been most effective in influencing practice.

Of the various individuals who early saw the possibilities in using the schools to give health services to children, there were three who were in positions which enabled them to be unusually effective in influencing legislation and in setting the patterns for service. They were Dr. James Frederick Rogers of the United States Bureau of Education—later the United States Office of Education; Miss Sally Lucas Jean of the American Child Health Association; and Dr. William A. Howe, first chief of the Medical Inspection Bureau of the New York State Education Department.

School health policies. Reports of the Educational Policies Commission of the National Education Association and the American Association of School Administrators have furnished a basis from which more specific statements have been developed. The Commission's reports on *The Purposes of Education in American Democracy* ⁽¹⁾ and *Social Services and the Schools* ⁽²⁾ are especially pertinent.

The National Committee on School Health Policies formed by the National Conference for Cooperation in Health Education produced a concise report, *Suggested School Health Policies*, ⁽³⁾ consistent with the philosophy and recommendations of the Educational Policies Commission. Because of its authoritative origin and practical usability, this has proven one of the most popular publications in the school health field. If a school is to rely on a single reference for use in developing its own policies, this is the logical choice. However, *Health in Schools*, ⁽⁴⁾ the Twentieth Yearbook of the American Association of School Administrators, is recommended as a more concrete help in developing the detail necessary for use in a school health service and for application to the special problems found in the school.

School medical service. In this sector of the school health program, the publication, *Health Appraisal of School Children*, ⁽⁵⁾ by the Joint Committee on Health Problems in Education, answers many of the questions that arise in designating the physician's part in the service. It is well supplemented by the Reports of the First,

Second, and Third National Conferences on Physicians and Schools,⁽⁶⁾ of the American Medical Association.

The concept of the physician's function in *Health in Schools* is sufficiently consistent with those of the Joint Committee and the Conference reports to make practical the use of the administrative procedures it describes in implementing the medical policies advocated.

Dental program. In a general way the dental program is covered in the publications of the Educational Policies Commission and the Joint Committee on Health Problems in Education. For greater detail the publications of the Council on Dental Health of the American Dental Association are available.⁽⁷⁾

Conservation of vision and hearing. With the exception of laws concerning communicable disease, there are more state mandates to the school health services in the fields of conservation of vision and bearing than in any other. The requirements are usually minimal, and a school system which employs a nurse is apt to have programs in these areas which go beyond the state provisions.

Standards set up by the National Society for the Prevention of Blindness⁽⁸⁾ have been the basis for the general pronouncements relating to the conservation of vision in the laws and policies mentioned above. To a lesser extent, those in relation to conservation of hearing have been based on "A Hearing Conservation Program"⁽⁹⁾ formulated by the Committee on Hard of Hearing Children of the American Hearing Society. Materials prepared by the American Academy of Ophthalmology and Otolaryngology also offer guidance.

Development of new equipment, techniques for use in school programs, and research checking the results of various activities carried on for school children are matters of first interest in these organizations. As a result new standards are set and amended recommendations issued. There is an unavoidable lag between the issuance of new statements and their official inclusion in publications such as those referred to above by such organizations as the Joint Committee and the American Association of School Adminis-

trators. It is, therefore, necessary for those interested in current standards to go directly to the vision and hearing groups for possible new developments and to watch the current publications of the National Education Association and the American Medical Association for the adoption by their appropriate committees of the suggested revisions.

Communicable disease control and prevention. The American Public Health Association, a professional group, issues standards for the control of communicable disease.⁽¹⁰⁾ These are not always accepted by official agencies. Standards set up by the national official agency, the United States Public Health Service, are not necessarily consistent with these, nor are standards of the various states the same as those of the USPHS. Within the states *community regulations may differ from those of the state health department.* Sometimes the communicable disease regulations for the school differ from those of the city, village, town, or county in which it is located. This is understandable because the local school authorities are responsible for all that goes on in the school and respect, if they cannot change, local viewpoints in order to receive cooperation.

For the present purpose, the APHA standards will be assumed as a basis for discussion of the problems in communicable disease control involved in the nurse's work.

Safety program and care of emergencies. In this program the National Safety Council is the generally accepted authority. The principles embodied in both *Suggested School Health Policies and Health in Schools* are consistent with its pronouncements. This is a field in which new developments occur frequently, with many amended recommendations being issued; therefore, it is desirable to keep in touch with the council publications.

Areas in the school health program lacking accepted plans. There are areas, such as nutrition, mental hygiene, sanitation, and health supervision of students engaged in competitive sports, in which there is a most confusing lack of agreement among the various authoritative groups. Many statements by such groups as the White House Conferences and survey teams of various agen-

cies point out the needs in these fields. Agreement exists as to certain needs but not on what should be done about them and how it should be done.

Early ideas of the need for and place of the nurse. The first nurse to go into the school was Amy Hughes of London in 1892. Her purpose was related to an inquiry being made concerning the feeding of school children.⁽¹¹⁾ Other "Queen's Nurses" were placed in the London schools in the next few years and some by the London School Nurses Society. This was organized in 1898 by a nurse, Honnor Morten,⁽¹²⁾ who was a member of the school board. Voluntary funds paid for a school nurse in Liverpool in 1893.⁽¹³⁾ In 1900 the London School Board appointed a temporary nurse; in 1904 the London County Council appointed a permanent staff of nurses with a nurse superintendent.

The chief purpose of the early English nurses seems to have been to treat in school the communicable skin and scalp diseases which caused many children's failure to receive an education. In the period before the employment of nurses, they were excluded with no follow-up to secure treatment.⁽¹³⁾

It was for similar treatment that the first nurse was assigned to school work in this country. In 1902, Lillian Wald of the Henry Street Settlement Nursing Service placed Lina Rogers in four elementary schools in downtown New York City. Three were public schools, the fourth, parochial, with a total of about 10,000 pupils. In three months, twelve assistant nurses were appointed and the office of Superintendent of School Nurses was created for Miss Rogers who became the first municipal school nurse. Two months later, fifteen more nurses were added. Under the direction of Miss Wald and with the assistance of such fellow workers as Yssabella G. Waters, J. E. Hitchcock, Mrs. Florence Kelley, and Lavinia Dock, Miss Rogers organized a working system for the new service, which was widely copied throughout this country and Europe.⁽¹²⁾ Here as in England the nurses had soon found that the children needed many other things which nurses could do for them in addition to the treatment of communicable diseases.

In 1911 a survey was made by the Russell Sage Foundation of

1046 school systems in 1038 cities and towns. These constituted nearly 90 per cent of the American municipalities which had systems of public schools under superintendents. The survey showed that 443 or 43 per cent had regularly organized systems of medical inspection. Of the 443 systems, 102 employed 415 school nurses, 375 or 90 per cent of which were in the North Atlantic and North Central states.⁽¹⁴⁾

In 1908 the Russell Sage Foundation published the first edition of *Gulick and Ayres' Medical Inspection of Schools*. The preface of the 1913 revision contains this statement:

The school nurse, almost unknown four years ago, is now an important adjunct of the systems of scores of cities. . . . She is the teacher of the parents, the pupils, the teachers, and the family in applied, practical hygiene. She is the most effective possible link between the school and the home.

In the chapter "The School Nurse" it is stated:

The value of the school nurse is the one feature of the medical inspection of schools about which there is no division of opinion. Her services have abundantly demonstrated their utility, and her employment has quite passed the experimental stage. The introduction of trained nurses into the service of education has been rapid, and few school innovations have met with such widespread support and unqualified approval.

The reason for this is that the nurse supplies the motive force which makes medical inspection effective . . . wasted effort if the parents fail to realize the import of the notification [of the defect] or if there is no family physician to consult.

. . . her work prevents loss of time on the part of the pupils. . . . She gives practical demonstrations in the home of required treatments, often discovering there the source of the trouble. . . . Her work is immensely important in its direct results and far-reaching in its indirect influences. Among foreign populations she is a very potent force for Americanization.

The following description of the duties of the nurse is given:

The functions of the school nurse are most varied in different communities and include duties which range from the reporting of cases of

truancy to diagnosing contagious diseases—two extremes, neither of which properly falls within the purview of her work. In general, her duties may be concisely summarized as follows:

1. In the school:

(a) Making routine physical examinations of children to detect those cases which should be referred to the school physician.

(b) Assisting the physician in making physical examinations and recording results.

(c) Acting in emergency cases such as caring for accidents, bandaging cuts, removing splinters, caring for cases of fainting, convulsions and the like.

2. In the home:

(a) Explaining to parents, the significance of the notices sent by the school physicians concerning the condition of their children and aiding the parents in securing remedial action.

(b) Instructing and educating parents in the practices of applied hygiene.

3. In the clinic:

(a) Assisting the physicians in treatments and operations.

(b) Leading the children to view the proceedings of the clinic as diverting experiences rather than terrifying ordeals.

Development of the functions of the nurse in the schools of England. By 1912 in England and Wales "more than" 742 nurses were working in the schools. Of the total 317 local education authorities, 241 reported 742 nurses of whom 397 were full time and 345 part time. Not included in this number some additional local authorities had made arrangements with local nursing organizations for nursing.⁽¹⁸⁾ Roberts, describing their work, says:

There is no more important factor in any system of medical inspection than the school nurse. In some instances she assists the physician, in other instances she does some of the inspecting herself. She fills a valuable place in the treatment clinic, where she applies the routine measures

for many minor ailments. Her most important work probably is that of home visitation; she shows the necessity of following the medical inspector's advice and also how to carry out the treatment for minor ailments.

Statement of health officers group. The State and Provincial Boards of Health at their Annual Meeting in 1911 included in their resolutions concerning desirable legislation providing the medical inspection of school children this endorsement: ⁽¹⁴⁾

We endorse the school nurse as a most valuable adjunct of medical inspection and believe that provision for the employment of school nurses should be included in each law.

Early statements by American nurses. The Cleveland Visiting Nurse Association, beginning in 1909, published *The Visiting Nurse Quarterly*. When the National Organization for Public Health Nursing was organized in 1912, this little magazine was turned over to it and publication continued, first under the name of *The Public Health Nurse Quarterly*, later as *Public Health Nursing*, and now as *Nursing Outlook*.

Since Cleveland was one of the early cities to develop school nursing and Western Reserve was one of the first universities to include preparation for the school work in the course for public health nursing, it is not surprising that all of the early issues of the magazine contain much material relating to school programs. There were presentations of both sides of some of the controversial questions that are still unsettled—such as *generalized nursing in the schools versus specialized*, and *should school health nursing be administered by the health department or the board of education?*

At NOPHN's first annual meeting in 1913, Anna M. Stanley,⁽¹⁵⁾ in describing the program in Cleveland, said:

Up to the present time the main efforts of the school nurse have been directed to correctional methods, and little or no emphasis laid on the preventive side through education, while now we come to realize that this indirect influence is the most far reaching in its results.

At this time the school nursing staff in Cleveland consisted of a supervisor and 17 "assistants" working under the board of education. In addition to the usual work of the nurses, they were working under the direction of the special examiner for backward and mentally defective pupils to study the family situations of these children. Miss Stanley said:

A few of the more seriously retarded children were picked out for investigation. The objective of this was to show by means of charts the appalling number of feeble-minded persons in family groups and the urgent need for segregation. In a family of four generations the nurse . . . in a unique piece of work . . . succeeded in getting reliable and accurate information on 52 relatives. Out of that number there were 24 feeble-minded individuals. The great grandmother was feeble-minded to start with.

Speaking to the annual meeting of the American School Hygiene Association in New York City in 1916, Ann Hervey Strong, then instructor in the Department of Nursing and Health of Simmons College, said: ⁽¹⁷⁾

For here [in school nursing] we have a form of service belonging not only to public health but also to education, both of them highly active social movements. As they broaden and develop, so must school nursing develop and broaden, charged always with its double sense of responsibilities. Clearly then the training of women for school nursing, while in part identical with the still unsolved problem of the best training for public health nurses, presents also [additional problems] . . . a program such as this . . . in the usual school . . . is already taxing heavily each nurse's skill and ingenuity and intelligence. Yet constantly more and different demands are made upon her. This is especially true in communities where work is new or just about to be established, as administrators more and more realize the value of health as a factor in the educational process.

Miss Strong enumerated some of the requests the college had had for nurses with additional training. Various desired were: preparation to direct all the recreational work; a nurse with normal training and successful experience in teaching; preparation to act as social director in a normal school as well as a nurse; ability

to direct the physical education program; teach handwork; organize clubs of various kinds; direct the truant officers; preparation to organize the health work in communities where there was no medical inspector.

Some "lay" opinions on the function of the school nurse. In 1913 New York State had passed its Medical Inspection Law which authorized the employment of school nurses by boards of education. The first reference to such nurses is found in the annual report of the State Education Department and included the following statement: ⁽¹⁸⁾

A registered nurse who has been admitted to practice in this state may be employed as a school nurse. Our experience shows that the best service will often be rendered through the employment of a full-time nurse who may do much of the work required under the medical inspection law in the physical examination of school children, in following up cases of children who are ill or physically defective, and in providing proper treatment for such children.

As an industrialist, William Alexander Field, general superintendent of the South Works of the Illinois Steel Company, spoke to the industrial nurses session at the second annual meeting of the NOPHN in 1914. He spoke on "Civic Control of Public Health Nursing" and said: ⁽¹⁹⁾

The future function of the public health nurse as I see it is that of a teacher at the head of a department in each school where health, hygiene, and sanitation will be taught and demonstrated just as any other part of the curriculum.

School nurse as a "team member." At the fourth annual convention of the National Organization for Public Health Nursing in 1916 a paper was given on "Cooperation as a Factor in the Work of the School Nurse." ⁽²⁰⁾ Its closing sentence was:

Cooperation then must be the keynote of the school nurse's work if she hopes to reach the highest possible plane of achievement, cooperation which has for its object only the physical and moral betterment of the child; and which in its essence, resembles somewhat the spirit of

the college athlete to whom the individual is important only in relation to The Team.

The paper itself, although this was not mentioned, was prepared by a "team" of four supervising field nurses of the Chicago Health Department.

Miss Gardner's 1916 statement. In the 1916 edition of *Public Health Nursing* Mary Sewall Gardner said: ⁽²¹⁾

Her [the nurse's] duties [in the school health program] may, perhaps, be divided into three groups; her work with individual children at the schools, her work with individual parents at the homes, and her work as an assistant to the doctor and teacher in matters pertaining to health.

The discussion continued with helpful and in many cases modern-sounding suggestions for the nurse who is going to work in the schools. It is interesting to compare her ideas with present-day educational thinking. For the purpose statements regarding current trends in school nursing will be used as they are described by Dr. Ruth Strang in *Monroe's Encyclopedia of Educational Research*. ⁽²²⁾

One of the present trends shows the nurse working with and through the teacher. Miss Gardner emphasized that it was the nurse's duty to "strengthen the hands of the teacher" and referred to the nurse's work as "assistant to the teacher in matters pertaining to health," and to the nurse herself as a "coworker of the teachers" who will "simplify and render more valuable their own [the teachers'] work."

Another trend is toward making the school and community health center the core of health education. Although the term "community health center" had not been originated in 1916 and "health education" was still to come into general use, the spirit of this development is undoubtedly what was in Miss Gardner's mind when she said "the nurse's instructive ability will be tested to the full in giving routine treatments to skin disease cases" and in the detailed attention she gives to helping the nurses plan for using their school contacts to develop not only mothers' meetings but school health leagues and little mothers' leagues for group teaching of children

themselves. She admitted that the nurse unaccustomed to talking to groups might find this work difficult but advised that it was "an art that can be acquired" and suggested that it was better to hold their attention for five minutes by a simple talk than "to discourse most eloquently for half an hour to inattentive ears." By a wise and frequent use of questions, very young children may be led almost to give the talk themselves, thereby arousing their enthusiasm and holding their interest. Thus more than a generation ago, Miss Gardner was pointing the way for the nurse's use of group discussion.

A third trend Dr. Strang points out is toward having the nurse do "more individualization of instruction and guidance of individuals." In addition to her repeated references to the nurse's work with individual pupils and with individual parents, Miss Gardner warned the nurse not to let herself forget "the influence brought to bear on the individual child is of the utmost importance, and the nurse must not let the necessity for this part of her work slip her mind in dealing with the children."

The fourth modern trend quoted in the *Encyclopedia* is toward encouraging the family's feeling of responsibility for its own health improvement. That Miss Gardner subscribed to this was indicated by such phrases as "the teaching of self help," "strengthen parental responsibility in new directions," "the care given in school is the ameliorative, and that given in the homes, the preventive, work," "the nurse who merely cares for her patients and leaves them ignorant of how to give this care themselves has long been considered a poor public health nurse."

In discussing the health service in general Dr. Strang mentions two practices which are needed but are not yet generally attained. Miss Gardner also mentioned these: (1) parents should be urged to come to the school for their children's medical examinations; (2) cumulative records should follow the child through his school life. "The best type of record," Miss Gardner said, "is one which follows the children from grade to grade and from school to school."

Miss Gardner wrote this chapter when school nursing was hardly into its second decade of existence. Nevertheless, her vision went

far beyond the school treatment of contagion for which it was originated. It was also in advance of the next step which had been taken by some of the school physicians and administrators in school systems with medical inspectors. This was promotion of the nurse's efforts to persuade parents to follow recommendations made by the medical inspector. Miss Gardner saw the nurse as offering something of her own and not just as an implementer of the physician's work, or, less desirable, as a substitute for a physician.

First book on "school nursing." In 1917 *The School Nurse* ⁽²³⁾ by Lina Rogers Struthers was published. In 1909 Mrs. Struthers had left the work she started in New York City and gone to Pueblo, Colorado, to organize school nursing under the board of education. In 1910 she became superintendent of school nurses in Toronto, Canada. The first school nurse in Canada had been appointed in Hamilton, Ontario, in 1907, followed by two nurses doing similar work in Montreal in 1908, two in Winnipeg in 1909, and one in Vancouver in 1910. In Winnipeg clerks were appointed to assist doctors and nurses with clerical work.

Mrs. Struthers had a good working knowledge of school nursing services in various cities of this country and Canada. She believed as Miss Cardner did that when a school nursing service moved beyond exclusion for communicable disease, it is best carried on by the board of education rather than continued as a function of the board of health, but she was much more aggressive about her belief. She considered health education to be the fundamental basis of all school health work, with the cure of disease or removal of physical defects as a necessary but incidental part of the work.

Since Mrs. Struthers considered that wholesome food, proper clothing, personal cleanliness, physical drill and play, and plenty of fresh air in school and home were the factors of greatest importance to the child's future welfare, she devoted much of her book to a discussion of these things and how the nurse could help secure them for the child.

She recognized that school nursing was only in its infancy and advised her readers that many changes in method were to be expected.

She urged the nurses to *keep before* the teachers, trustees, and the people the desirability of making the school the center of the social life of the district. If case conferences were not being held, she suggested that the nurse try to bring them about to prevent overlapping and paupering in relief work, and to relieve the immediate needs of the families concerned at the same time guiding them to learn to provide for themselves. In a city large enough to require it, she recommended that records be kept by a central case conference association or a neighborhood workers association and be available at any time for reference. School baby clinics were advocated as well as little mother's classes. Said Mrs. Struthers:

Education wisely interpreted, concerns the body as well as the minds of the pupils, and the first essential duty of the school board is to see that the child is intelligently cared for during the intervening years, from birth to school life.

Parental responsibility, Mrs. Struthers emphasized:

. . . the school nurse must know that parents have responsibilities toward their children and that no one else can or should undertake these responsibilities. . . . The health of the school child is the most vital question before any state, for on this depends national existence and success, but governments have been slow to recognize this fact . . . under the changing social conditions of present-day life, the public school will have to assume a larger and larger share of the duties and responsibilities that should properly fall upon the shoulders of the parents . . . in modern life mother instinct is an inadequate guide for the rearing of children into capable men and women. The mother needs the assistance of those with special knowledge and teaching aptitudes. There should be more intimate relations between the parent, the school teacher, the school nurse, school dentist, and the school physician, in the social life of the community, as well as a more active cooperation in the school work. . . . The function of the school nurse, dentist, and physician is to guard the physical well-being of the child, and thus increase the efforts of the teacher, and render the parents that scientific knowledge that secures the fullest development of the child.*

These statements sound as though they might have been quoted from the 1950 White House Conference.

* Struthers, Lina Rogers: *The School Nurse*. G. P. Putnam's Sons, New York, 1917.

Throughout the book there is a continuing emphasis on the unique nature of the nurse's services in the school, on her aim toward prevention as well as cure, that she must not be looked upon as a "mere helper" of the medical inspector and dentist and that she should never forget that she has her "own schedule to carry out." She points out that the reason medical inspection is a "blessing to children" is not the careful medical examination, nor the scientific diagnosis, but "the remedy that is produced." For this she says the credit must go to the school nurse. The nurse also is considered "in a very special way, in loco parentis" to the children.

The nursing supervisor is considered so much a part of the picture that in listing the duties of the school nurse, Mrs. Struthers uses the heading "Duties of School Nurses and Supervisors." Where there was a school medical inspector the nurse was to work subject to his instruction; if nurses only had been appointed, "subject to instructions from the School Superintendent or to the Principal of the school." In the latter case she was to make an examination of each child and report it in writing to the principal; she was to notify the parent or guardian through the principal of any condition found. Additional duties included care of emergencies, home calls, records, and reports.

"*Rural school nursing*," Red Cross, 1921. The Red Cross had inaugurated rural nursing service in 1912 and after the ending of the war in 1918, it expanded rapidly as chapters were well organized and had money to spend. Its Town and Country Nursing Service was responsible for the introduction of nurses into many rural schools.

The Red Cross first published *An Outline for Rural School Nursing Procedures* in 1921.⁽²⁴⁾ This was prepared by Anna Louise Stanley, who in 1903 had been placed in the public schools of Philadelphia by the Philadelphia Visiting Nurse Association. She became active in the work of the National Organization for Public Health Nursing on school nursing. Later, while employed by the Cleveland Board of Education she had been responsible for an informal "field training" given to numberless nurses who came to "visit" the Cleveland system to learn how to carry on such a service in schools to which they had been recently appointed. In the school

year of 1915-16 there had been 41 such nurses. Therefore in the summer of 1916 Miss Stanley had participated in organizing a course for school nursing in the Cleveland Normal School, the first course to be offered in a normal school.

Her broad experience enabled her to prepare a pamphlet which not only was of great practical help to Red Cross and other school nurses, but which operated also to focus public attention on the need for nursing service in rural as well as in city schools.

In 1925 the publication was revised by Helen Teal and Elizabeth G. Fox, and issued under the title "Rural School Nursing." A third revision in 1931 was largely the work of Katharine Faville and Margaret Reid.

Miss Gardner's 1924 statement of function. The second edition of *Public Health Nursing** was published eight years after the first. In it appears a more detailed statement but one which advocated the same type of service by the nurse which was described in the first edition:

In review it may be said that the duties of the school nurse are:

1. To acquire such understanding of the development of modern health education as will make clear her own relation to it.

2. To assist the teacher by advice and counsel in the furtherance of the work of health education.

3. To assist the teacher to inaugurate and carry out a satisfactory system of routine health inspection.

4. To assist the school doctor in his periodic examination of the children, and to care for such minor dressings as may be referred to her. In case no doctor is available, to make such examinations as will enable her to bring to a physician's attention those cases requiring his services.

5. To induce parents, through her most important function of home visitor, to secure for their children as healthful conditions as individual situations will permit, and to persuade them to have the defects discovered remedied. In addition, to make clear to them the fundamental principles underlying modern health education, to the end that they may intelligently play their part in the health progress of their children.

* Gardner, Mary S. *Public Health Nursing*, 2nd ed. The Macmillan Company, New York, 1924, pp 341-42.

Statement in the Manual of Public Health Nursing in 1926. The National Organization for Public Health Nursing in its *Manual of Public Health Nursing** included in its statement of what public health nursing provides:

Supervision of the health and habits of the school child with an active interest in the health of the school personnel, that there may be a healthful school environment and health instruction; the teaching of first aid, home nursing, home and personal hygiene and infant care for school children.

School nursing in Lincoln, Nebraska, 1926-28. As director of the Department of Physical and Health Education of the Lincoln Public Schools, Harvey L. Long had become interested in finding an answer to the question, "What do nurses do?" (25) A study was made based on analysis of the nurses' daily-weekly reports covering selected periods over the two years, of daily diaries kept by eight nurses for 50 half days, and a review of home calls made over a period of 33 weeks.

Pupil loads varied from 1247 to 2120 with the number of school buildings covered by each nurse varying from two large buildings to six small ones. No regular classroom teaching was done by these nurses.

Averages were worked out for the number of times certain things were done per week by the nurses, showing: 4.5 classrooms inspected and 3.8 classrooms in which bearing and vision were tested; an average of 4.6 homes were visited each week per nurse and 1.6 (other) parents consulted; conferences were held with 4.4 principals and 10.6 teachers each week.

The nurse "consulted" with 8.8 pupils; 18.2 had their temperatures taken; she vaccinated 3.1 and did vaccination dressings on 27.8. Treatments were given, most of which—46.5 per week—were classified under "miscellaneous" while those for impetigo averaged two a week and less than one per week were given for each of general ringworm, ringworm of the scalp, inflamed eyes, pediculosis, and scabies.

* National Organization for Public Health Nursing: *Manual of Public Health Nursing*. The Macmillan Company, New York, 1926, p. 7.

On the basis of the half day diaries, the average percentage of the time spent by eight nurses was found to be: Pupil conferences, including health conferences with pupils soon to enter school, 16.1 per cent; "first aid, examinations, exclusions, temperatures, etc.," 19.7 per cent; teacher conferences 4.8 per cent and principal conferences 4.1 per cent; telephone calls 5.1 per cent and home calls 11.2 per cent with an additional 5.5 per cent for "in transit."

Vaccination clinics averaged 5.2 per cent and cleaning, caring for, and arranging equipment which included preparing for clinics and cleaning up afterwards, 6.3 per cent.

The rest of the time went for inspection of classrooms, 4.1 per cent; clerical work, 11.3 per cent; and work in the office of the department and school physician, 2.2 per cent.

There were great individual differences in these averages for the eight nurses. For instance the fewest average number of home calls per week for a nurse was 2, the largest number 10. The average percentage of time spent on pupil conferences varied from 1.5 per cent to 22 per cent; on clerical work from 5.3 per cent to 15 per cent; on telephone calls from 1.5 per cent to 15 per cent; on inspection of classrooms from 2 per cent to 12.9 per cent. It was considered that, while there were some differences in the situations in which the nurse worked, to a great extent the nurse's preferences determined the emphasis she gave to certain of her activities and that a definite value resulted from the opportunity for the nurse to compare the distribution of her time with the averages for all.

School nursing in Toronto in 1928. The report of the Toronto Department of Health presented at the Sixth Annual Meeting of the American Child Health Association gives the following picture: (26)

There were 90,109 school children registered in the public and separate schools of Toronto in 1928. The public health nurses made 19,730 classroom inspections and 89,877 home visits and consultations on behalf of these school children. There were 28,500 routine complete physical examinations made by the Department physicians and 7,250 special examinations. The Junior Health League or Mother Craft Classes held in other years were discontinued in 1928 because of shortage of staff.

It is hoped that they will be incorporated as part of the school curriculum when re-established. The mental hygiene division of the Department with a staff of one psychiatrist, two nurses, three psychologists, and a stenographer, examined 1,468 school children and had 308 who were found to be mentally defective, placed in special classes. The staff of this division also acts as advisors to the nurses in the field, helping them to teach the mothers the principles of child training, and to recognize and handle every symptom of maladjustment.

In 1928, in the interest of health and hygiene, 140,729 visits to and consultations on behalf of children of all ages were made. In the interest of nutrition of children, 8,393 visits and consultations were made. In the interest of the prevention and cure of tuberculosis in children, 10,261 visits and consultations; in the interest of the prevention and cure of acute communicable diseases in children, 17,076 visits and consultations; of prevention and cure of venereal diseases, 4,021 visits and consultations; and in the interest of mental hygiene, 2,916 visits and consultations.

In California in 1929. Speaking at the Sixth Annual Meeting of the American Child Health Association, Dr. Sven Lokrantz, medical director of the Los Angeles City schools described the requirements for a school nurse in California.⁽²⁷⁾

... that she be a registered nurse and hold a Health and Development Credential and have some experience in public health work. Every nurse before she is employed as a school nurse should have practical field experience in school health work and she should also have the training required to become a Public Health Nurse. A nurse coming directly out of training school is not fitted for school health work without further training. She should have a fundamental knowledge of contagious diseases, skin diseases, conditions of the eye, ear, nose and throat and knowledge of malnutrition in children. She should have some knowledge of school sanitation. Her knowledge should include corrective physical education and she should be able to recognize orthopedic conditions. She should be able to teach health. She should have a knowledge of social service, oral hygiene, first aid, and she should have clerical qualifications.

Statement in 1932 edition of the Manual. In the second edition of the *Manual** in 1932, the general objectives of a public health nursing service to school age groups were stated as:

* National Organization for Public Health Nursing: *Manual of Public Health Nursing*, 2nd ed. The Macmillan Company, New York, 1932, pp. 152-53.

To assist in communicable disease control by the recognition of early symptoms and by securing immunization.

To assist the physician in medical inspection and in the routine periodic physical examination of every school child.

To assist in securing the correction of defects and in promoting health.

To assist in securing special examinations and such follow-up as is necessary.

To participate in the promotion of hygiene and sanitation of the school plant.

To assist in securing proper instruction of pupils and parents in the principles of healthful living.

To provide or supervise adequate nursing care to all sick children.

. . . . The nurse thus serves as a connecting link between the home, the school and the community and can utilize the interest of all groups to help in the promotion of the health of the child.

Miss Chayer's "School Nursing" (28) in 1931. This book may be regarded as marking the coming of age of school nursing as a distinctive service and as an educational instrument. Its subtitle, "A Contribution to Health Education," was justified by its contents as also was the statement made in the introduction by Katherine Tucker that the author "interprets health not just as it relates to his [the child's] physical well-being, but as that which is the dynamics of his adjustment to all life."

Mary Ella Chayer had been a public school teacher before she became a nurse. Since 1919 she had been immersed in school nursing and health education—practicing, directing, studying, and teaching, and always the two together. As a result she was able to show that nursing service in the school was something more than

as those set up by the National Organization for Public Health Nursing and applied to them a spirit and a philosophy which involved in the service rendered in the school the application of modern psychology's educational methods as well as application of the truths of medical science.

Nursing service in high schools was far behind that in elementary schools, partly because high school administrators did not feel the same kind of pressure to obtain it, problems being less on the surface in the secondary age group, and partly because the high school organization was so much more complicated that many nurses hardly knew how to start. Discussion of the secondary program gave impetus to development of new high school health services by convincing administrators of their value. By helping the nurses see new possibilities, established services were improved. The second edition of Miss Chayer's book in 1937 added more helpful material in this area.

The Nurse in the School: an Interpretation. This was prepared in 1939 by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association in cooperation with the Education Committee of the School Nursing Section of the National Organization for Public Health Nursing.⁽²⁹⁾ In this, ten objectives of the nurse in schools were stated:

1. To stimulate in every child a desire to safeguard his own health through intelligent application of scientific knowledge. This involves an understanding of the child by the nurse, the teachers, and the parents, and a recognition of the need for health supervision, under medical direction, at home and at school.
2. To assist the school in its program of home and school cooperation in matters pertaining to health.
3. To establish rapport with all members of the school personnel through economical and coordinated effort based upon a true knowledge of existing conditions.
4. To contribute to the school's aims in educational and vocational guidance.

To assist in communicable disease control by the recognition of early symptoms and by securing immunization.

To assist the physician in medical inspection and in the routine periodic physical examination of every school child.

To assist in securing the correction of defects and in promoting health.

To assist in securing special examinations and such follow-up as is necessary.

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Mary Ella Chayer had been a public school teacher before she became a nurse. Since 1919 she had been immersed in school nursing and health education—practicing, directing, studying, and teaching, and always the two together. As a result she was able to show that nursing service in the school was something more than a part of the educational system as carried on in the school, that it projected into the home and the community as part of the child's life.

She saw the nurse in the school as a combination of nurse, teacher, and social worker. She quoted the nurse's functions in the school

administrator, the teacher, the parents, the physician, and a wide variety of community agencies and groups in getting these needs met.

. . . the nurse usually has the most intimate relationship with the home.

In helping to improve and expand community health facilities, the nurse in the school works as a member of health committees, assists with community projects, and provides health information . . . assists the physician in preparing for and conducting the health examinations of school children . . . encourages presence of parents at health examinations of children of elementary school age . . . gives physician advance information regarding the child . . . helps teachers and parents to recognize significant departures from normal in their day-by-day contact with children . . . by acquainting teachers with suspicious signs and symptoms which should be reported immediately . . . arranges for the isolation and care of sick children while they are in the school building.

. . . assists in coordinating all available information regarding the health status, health behavior, home environment, and progress of each child so that it can be used in getting maximum practical results in the way of needed remedial work or correction of poor health practices or poor environmental conditions. . . . A large part of her time is spent in guiding and encouraging parents in their efforts to get their children's defects corrected or to provide the best possible conditions for healthy development of the children. . . . She coordinates her work with that of other public health nurses in the community so as to save time and overlapping of services.

. . . she assists in developing modified school experiences for children with special needs . . . helps to implement a planned program for the protection of all children. This includes arranging special examinations for children participating in strenuous physical activities . . . aids in the encouragement and promotion of health programs for school personnel . . . works with the school staff, the children, and the parents to see that safe and hygienic conditions are maintained . . . in cooperative efforts to provide a healthful emotional and social environment, the nurse acquaints the administrator and the physician with conditions encountered in her association with teachers, children, and parents which affect healthful adjustment to school situations and aids in their solution. . . .

The function of the nurse in the school in health teaching is chiefly advisory . . . in the planning of the health curriculum . . . she may help to determine what phases of the health program can be used as

5. To lend intelligent help to the school in its task of promoting and maintaining a healthful school environment, physical, emotional and social.

6. To create a desire for and a knowledge of how to obtain medical and dental service.

7. To contribute to the community's plan for prevention and control of communicable diseases by interpreting that plan to the school personnel and by helping the school and its pupils, and parents, to assume their share of responsibility for furthering the plan, not only with respect to school age children but also with reference to families of which they are a part.

8. To assist the school administrator and the physician to secure for every child the most immediate and intelligent care possible in the situation in the event of illness or injury at school, and to give parents intelligent leadership in securing further medical advice and treatment.

9. To aid the school in its problem of attendance, placing emphasis upon legitimate absence as well as upon regular attendance.

10. To assist the school to make available to the handicapped child opportunities for education comparable to those of the normal child, within the realm of possibility in the situation.

Statement by Conference for Cooperation in Education. In its publication *The School Administrator, Physician, and Nurse in the School Health Program: Functions and Education* ⁽³⁶⁾ * the functions of the nurse are dealt with in more detail than in the other statements referred to (detail too extensive to quote in its entirety). The following abstract indicates the general tenor of the thinking of the group:

. . . the nurse, serving the school, functions as a health consultant and adviser. She serves as a liaison officer between the school and the home, and aids in coordinating school and community efforts in health supervision and health instruction. . . . Her duties and responsibilities will vary according to the extent to which medical supervision of the children is available. In any case, she serves as interpreter between school, home, and community. She understands the health needs of children and serves on the team which includes herself, the school

* Courtesy of the Metropolitan Life Insurance Company.

Current statements by local agencies. In the 1950 Los Angeles County edition of *A Handbook for School Nurses* ⁽³²⁾ issued by the Office of the Superintendent of Schools appears a description of the nurse's place in health service for school children:

The school nurse of today has not only the responsibility of caring for physiological emergencies but she must assist in coordinating the total health program and serve as consultant to both administrators and teachers on health matters. Further she is expected to offer leadership in bringing together the home, school and community for the solution of common problems in the field of health.

Michigan Department of Health. In *The Nurse in the School Community* ⁽³³⁾ of the Michigan Department of Health there is no summary given of the nurse's functions but the following extracts are indicative of the service expected:

Her [the nurse's] major contributions to the school and community . . . to help the school to interpret the health and growth needs of the children and to aid the school and the health department in developing resources to meet those needs . . . is the liaison agent between the home, the school, and community health agencies. She works with the school although one of her major activities is family visiting. . . . The nurse should be a regular member of the school faculty although her salary may come from a different source. The nurse working as a representative of community health resources, and with her understanding of home relationships and health conditions, contributes a specialized service, either personally or through co-workers. This service may be either advisory or direct. Most of the direct nursing services are given to children through work with the family or through school community clinics. Advisory services are usually given through contacts with groups.

[In health services] . . . the nurse, acting in a liaison capacity, assists in formulating the policies. . . . The nurse assists the school in arranging for the planning group [to plan for health examinations] to meet, participates in the planning activities, and assists in making arrangements for the examinations. . . . The nurse and other health specialists should encourage teacher and parent observation of normal growth and deviation at different age level and help with in-service programs organized to study the needs of individual children. Through in-service programs, also, the nurse can help parents, teachers, and children develop skills to

learning experiences for the children . . . she assists in the development of educational activities which will promote skill in avoiding and in caring for accidental injuries. She may teach home nursing and first aid if she meets the requirements for teaching in the particular school she serves . . . helping children to become acquainted with community resources for recreation and health protection . . . help the teacher give older children opportunities for real participation in community health activities . . . help teachers to supplement and enrich their health teaching by keeping them informed of home and community conditions affecting the children. . . .

Current statement by the National Organization for Public Health Nursing. In 1947, the School Nursing Section's Committee on the Qualifications of the Nurse in the School⁽²¹⁾ included in its statement on qualifications a description of the functions of the nurse, as follows:

1. To participate with others in planning and developing a school health program which will take into consideration the personal and environmental needs of the child and which will promote the health of the school personnel.
2. To participate in interpreting the principles and plans which underlie healthful school living and to work with school personnel in establishing and maintaining a safe and healthful school environment including organization of the school day.
3. To work with appropriate administrative officials in developing and conducting school health services, and in interpreting their purposes and scope. . . .
4. To serve as a health adviser in curriculum planning, interpreting to the school staff home backgrounds and community conditions which affect the health of children, helping teachers to relate health instruction and guidance to specific needs; assisting in the selection of authentic health education teaching materials.
5. To help interpret the school health program to the home and community and the health needs of the home and community to the school, aiding them to coordinate their efforts effectively.

This statement was reviewed and reaffirmed by the 1949 committee of the section.

5. To aid in curriculum planning, through frequent conferences with the teaching staff.
6. To assist in projects for protecting or improving community health facilities.
7. To maintain records containing data pertinent to the school health program and to interpret such data to teachers, parents, and others.
8. To assist teachers in selecting children to be examined by the school physician or family physician.
9. To assist all school personnel, including teachers, custodians, cooks, and bus drivers, to maintain freedom from infections and to enjoy optimum health.

Other public health nurses: The public health nurse in the community has the same over-all aims as the school nurse in developing a health program for the school-age child. She can be of much help to the health directors in the schools of her community. However, she cannot spend all her time in developing a program around the needs of school pupils. She must strive to develop self-reliance on the part of the school staff by delegating many health promotion tasks to them.

The public health nurse is concerned with the health of all the families in her area, and considers the school health program as a valuable resource that may help these families to find and solve existing health problems in their own homes and in the community. Working with the family group, the public health nurse strives to surround the young child with the care it needs before it reaches school age, and so to offset serious health difficulties that frequently have their origin during the preschool years.

New York State Education Department. In the 1949 edition of New York State Education Department's *Work of the School Nurse-Teacher* ⁽²³⁾ the following outline is given of the nurse's school duties:

Subject to the direction and supervision of the superintendent of schools, to assist the school medical supervisor and other school officials in protecting the health of school children; teach health habits and health information through contacts with individual pupils, parents, and teachers; assist in health examinations of school children; visit homes in order to confer with parents regarding the health habits of children; secure the

be used in making screening tests. . . . The nurse is responsible for channeling pertinent information to the teacher. . . .

. . . the nurse should arrange for in-service education in first aid [for classroom teachers] . . . it is not necessary for the nurse to see the child to exclude him from school. . . . A nurse is not needed for the routine re-admission of children to the school. . . .

. . . school personnel may arrange a schedule of counseling time for the nurse . . . for boys and girls in school who will want to talk with the nurse about their own or their family problems. One of the nurse's greatest contributions to health services of children is the counseling of parents, of infants and preschool children.

The nurse contributes to health instruction . . . by supplying information to be used for the pupil's personal and curriculum guidance, by planning, by acting as resource person to the teacher, by helping with extra-classroom activities . . . she is used as a consultant.

[On school environment] . . . the sanitary engineer reviews with her his sanitation evaluation reports on the schools she serves. . . . She helps the teachers analyze the causes of nervous tensions in the room, and it may be necessary for her to coordinate the efforts of the teacher, home, and guidance agencies to relieve these tensions.

Minnesota's Joint Committee. In the 1950 edition of *Minnesota's School Health Manual*,⁽³⁴⁾ a Joint Committee of the State Departments of Health and Education states that the responsibilities of the school nurse include the following:

1. To interpret the school health program to the family in the home and to bring about a close liaison between the home and the school in all health matters. To encourage parents to be present at the health examinations of their children.
2. To help parents obtain the advice and assistance they need to solve family health problems.
3. To acquaint school personnel with school and community resources available for solving health problems.
4. To cooperate in the in-service health training of teachers through demonstrating techniques for observing children for signs of illness, for visual and auditory testing, weighing and measuring, and other health tasks.

or threatens. In more cases than not the disease is not a "major" disease but one of the skin or scalp as it was in 1902.

It may be that, in such a local community, the program may still have to go through the successive stages which we have reviewed. Whether administered by health department or school, it may have to go through the phase where the administrator or physician in charge, or perhaps both, insists that the nurse's activities be directed toward "saving the doctor's time." The period of time a service may require to come through the evolutionary stages and develop into a modern type service depends mostly upon the educational and professional preparation of the nurse and the type and amount of supervisory nursing service. The properly prepared nurse with effective supervisory backing will meet the original need in a way quite different from that possible for the pioneer nurse. In those first days of school nursing, the nurse came into the school and carried on activities which were actually the responsibility of the family and the family physician—the diagnosis of, prescription for, and treatment of communicable disease. When the same need arises in a school today the properly prepared nurse does not herself do something which can be better done by the family and family physician, but rather she uses community facilities, official and voluntary (most of which did not exist in that earlier day!), to strengthen the family and supplement its resources, so that the parents may meet their own responsibilities. There may also be involved educational work with the parents to help them realize what their responsibilities are in the matter.

It may be necessary for the nurse to stimulate development of more adequate community facilities to help parents. Always included is work with the child to help him to want the treatment which should be obtained for him.

Working with parents a continuing major function. Many books have been written and magazines have overflowed with articles describing the transfer to the school from the family during this last half century of educational responsibilities occasioned by changes in our cultural patterns. At the same time, however, there

treatment of defects and investigate the illness absences of children; give instruction in home nursing, child care, and first aid; inspect the school plant and report on its sanitary condition; assist in maintaining first-aid service; cooperate with the public health agencies in the development of family health and the control of communicable diseases; cooperate with the welfare agencies in the health supervision of families under their supervision and obtain treatment of defects of school children; advise teachers, principals, and the superintendent of schools with regard to all matters affecting the health of school children; and to do related work as required.

Effect of these statements of function on practice. It might be impossible to find a single school in any of the specific areas for which each of these statements was issued, in which the program as advocated by the directing agency is being completely carried out. The statements have definite value, nevertheless.

They are studied by administrators when a new service is being established or a change in program or procedure is being contemplated. The nurse and her supervisor use them, not, to be sure, as a builder uses his architect's plan, but more as a minister may use the text for his sermon. It is perhaps an inspiration toward which to work, or a point of reference from which to work out in various directions, or even a touchstone by which to test the validity of proposed plans.

The statement of function is carefully examined when the question arises as to whether the nurse should be admitted to the teachers' pension system, put on the teachers' salary schedule, or certificated as a member of the instructional staff. The legal advisor of the school or the nurse's personal lawyer scrutinizes the statement of function to the least detail when a suit involving possible negligence of the school or of the nurse comes up.

Repetition of the evolutionary process. It is possible in looking around this country today to find nursing services illustrating in a general way all of the statements of function quoted above, those which were included because of their historical significance as well as those titled "current." Nursing services are still being initiated in schools today because a communicable disease is present

In a like manner an experienced, well-informed teacher may help the inexperienced or unprepared nurse greatly in such matters as understanding child behavior, working with parents, and administrative practices in schools. Nor does this imply she can do the nurse's work for the nurse. In any case the child gains more from a good school nursing service if it is supplemented by and built upon good health supervision by the teacher in the classroom. But, however good the teacher's health supervision, it will not obtain for all children what they need if it is not complemented by adequate school nursing service. Working with, assisting, and being assisted by the teacher is always a function of any nurse working in the school or with school age children.

The nurse's function as a team member and as a leader in ideas. Reoccurrence in the present-day statements of such words and phrases as "the nurse assists," "helps," "aids," "participates in," and "prepares for" emphasizes her position as a team member. This conception has gained rather than decreased in prominence since it was first mentioned in 1916. Repetition of such phrases as "the nurse interprets," "coordinates," "encourages," "guides," and "advises" indicates her function of unobtrusive leadership.

The school nurse's primary function—working with and for the school child. In the thinking of educators and school administrators as evinced by their assignments to nurses in the schools, more importance is accorded the nurse's direct services to children as part of the pupil personnel services program than indicated in statements of function issued by or strongly influenced by health department administrators. When a child's needs must be met when he is away from his classroom group, or when he must be given a service for which the teacher does not have the technical preparation, the administrator is faced by the necessity of assigning the duty to someone other than the classroom teacher.

Some large school systems have many categories of nonclassroom personnel, such as deans, counselors or guidance workers, visiting teachers or school social workers, audiometer technicians, dental hygienists, and innumerable others. With all of these the nurse has many occasions to cooperate. But always, in addition to the

has been a sharpening of public concern that parents meet the responsibilities which are theirs and an improvement of laws designed to protect children whose parents fail to do so. In most states these laws are still inadequate, overlapping, confusing, and not generally understood by parents and sometimes not even by all the professional persons working with children. One thing is clear, however: parents still have both the privilege and responsibility of making decisions about medical, surgical, and dental treatments for their children. Unfortunately it is "legal" for parents to make such decisions colored by prejudice, ignorance, and misinformation, and the only protection which can be given to children against such decisions is through better parental education.

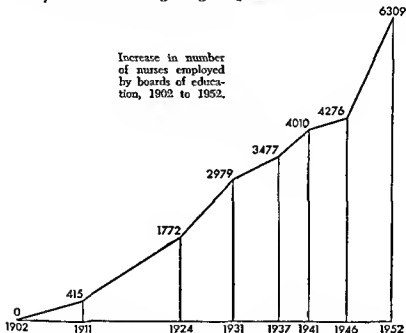
For these reasons, working with parents continues to be a part of the actual work of the nurse in the schools, as well as being the activity most generally considered of major importance in her program in theoretical statements.

Assisting the physician—a continuing function. A present-day nurse may find herself in situations in which she is asked to "take the doctor's place" and perhaps diagnose communicable disease, or decide which children should "be sent for" glasses or tonsillectomies, give treatment beyond first aid, or examine pupils to see if they should participate in competitive athletics. The properly prepared nurse is apt to respond by focusing attention on the many activities she can and should do which are not in the realm of medical practice but which are important in effective health supervision of pupils. She is able to show that these activities do "save," and make more valuable, the physician's time, by supplementing and implementing his work rather than replacing it. Her assistance to the physician continues to be an essential function.

Working with teachers—a major function. A parallel situation exists in relation to the activities of the teacher. It is not a question of the nurse "doing the teacher's work" nor of the teacher "doing the nurse's work." If the teacher is inadequately prepared or inexperienced, a well-prepared nurse can perhaps help her develop the skill and judgment needed to carry on health supervision. But the teacher's activities cannot be done for her by the nurse.

in 1924 and another in 1931. A count made in 1911 has been previously referred to (page 30). The last named three are much less accurate than those made by the Public Health Service but are probably indicative of the rate of growth. At any rate they are the only data there are regarding the periods stated.

Increase in number
of nurses employed
by boards of educa-
tion, 1902 to 1952.



The table on page 58, reproduced from Kilander's study, ⁽³⁶⁾ shows the extent to which nursing is provided, according to the city population groups.

The study shows also interesting variations within these population groups by regions. Of the 84 cities of 100,000 and over reporting, the range by regions for specialized school nursing services was from 100 per cent for West North Central (Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota) to 33.3 per cent for South Atlantic (Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia). For the generalized public health nurs-

times when she assists others in counseling the child, there are occasions when, to good advantage, the nurse counsels the child directly. She is in close contact with the social worker, but there are instances when she works with the family herself or with a community agency to accomplish some health purpose for the child. She helps the audiometer technician and the hygienist render their services to the child but she also works directly with the child and his family on hearing or oral health problems when the occasion demands.

The nurse is usually the first personnel worker to be added to a school staff, when staff reductions must be made, she is usually the last to go. When a nurse is assigned duties which would go to a specialized worker were such a person employed, it is not necessarily an indication she is expected to do work which is not "hers." Rather it is recognition of her ability as a "generalist," her sensitivity to the child as an individual, and her ability to see problems in all the fields of health—physical, social, mental, and emotional. It gives credit to her skill in using the problem-solving method of working which she absorbed in her hospital experience—to identify a problem, classify it, discover possible means, agencies, or individuals to deal with it, and to secure action.

Whether the nurse is the only health and welfare worker in the school, and perhaps in the community, or whether she is one of a large staff of personnel workers in a school in a highly organized community, the core of her function in the school is the same. It is to keep track of every individual in the school—pupil and employee, to ensure that he seeks and receives whatever health services he needs. Thus the pupil will gain the most benefit from his education and the school employee will give the best service to his job. The nurse will know that she has helped both pupil and employee at the same time to live a safe, comfortable, and happy life.

Employment of nurses by boards of education. Beginning in 1937, the United States Public Health Service has taken an annual census of public health nurses. Previously, the National Organization for Public Health Nursing had taken two census counts; one

NURSES EMPLOYED FOR PUBLIC HEALTH NURSING BY

	Boards of Education		State Education Depts.		Boards of Education		State Education Depts.
	SUPERVISORS •	STAFF •	SUPERVISORS |		SUPERVISORS •	STAFF •	SUPERVISORS †
Alabama	1	7		Nebraska	1	48	
Alaska	..	4		Nevada	..	8	
Arizona	..	87		New Hampshire	..	41	1
Arkansas	..	4		New Jersey	8	493	1
California	39	941		New Mexico	2	23	
Colorado	2	74		New York	9	1022	2
Connecticut	..	139	1	North Carolina	..	..
Delaware	..	49		North Dakota	..	..
District of Columbia	..	..		Ohio	6	206	
Florida	..	13		Oklahoma	..	37	
Georgia	..	13		Oregon	..	9	
Hawaii	..	4		Pennsylvania	10	803	1
Idaho	..	21		Puerto Rico	..	..
Illinois	13	249		Rhode Island	2	47	
Indiana	3	155		South Carolina	2	39	
Iowa	3	102		South Dakota	..	13	
Kansas	2	79		Tennessee	1	23	
Kentucky	..	1		Texas	11	477	
Louisiana	4	22		Utah	..	3	
Maine	..	22		Vermont	..	14	
Maryland	..	27		Virginia	2	78	
Massachusetts	7	246		Virgin Islands	..	..
Michigan	1	92		Washington	4	60	
Minnesota	6	174		West Virginia	2	31	
Mississippi	..	..		Wisconsin	1	25	
Missouri	3	157		Wyoming	..	16	
Montana	..	7		Total	147	6309	6

* From Federal Security Agency. Public Health Services, August, 1952 (mimeographed).

† From Official Directory of Public Health Nursing, *Public Health Nursing*, January, 1952.

ing program in the schools of these regions the reverse ranking occurred.

City population group	<i>Type of School Nursing Service</i>				
	Specialized school nursing service	Generalized public health nursing service	Combination of 2 and 3	Other plans	No pro- vision
	2	3	4	5	6
1	2	3	4	5	6
1	2	3	4	5	6
United States	54.1	30.6	7.9	1.7	5.7
Group I 100,000 and over	64.3	25.0	8.3	2.4	0.0
Group II 30,000 to 99,999	63.7	19.9	7.1	2.4	1.9
Group III 10,000 to 29,999	69.3	19.5	7.3	0.4	3.5
Group IV 2500 to 9999	45.3	36.9	8.2	2.1	7.5

Of the 211 cities replying in group II of 30,000 to 99,999 population there is a still greater range by regions: from 93.3 per cent in Middle Atlantic (New Jersey, New York, and Pennsylvania) which have specialized service down to 12.5 per cent in East South Central (Alabama, Kentucky, Mississippi, and Tennessee). In this same group, the highest percentage of cities with a generalized public health nursing program in the schools is South Atlantic with 58.6 per cent; it was in this same region in which the cities of 100,000 and over also had the highest ranking in generalized programs (see above). The lowest region in the group II cities with generalized service was Middle Atlantic (highest in specialized service) with 2.2 per cent.

Of the 563 cities of the group III, with 10,000 to 29,999 population, the regions with the highest proportion of specialized service

8. National Society for the Prevention of Blindness: *An Eye Health Program for Schools*. The Society, New York, 1951. 8 pp. \$.10.
9. American Hearing Society, Committee on Hard of Hearing Children: "A Hearing Conservation Program," *Hearing News*, 18:8, (May) 1950.
10. American Public Health Association: *The Control of Communicable Disease*, 7th ed. The Association, New York, 1950. 159 pp.
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12. Struthers, Lina Rogers: *The School Nurse*. C. P. Putnam's Sons, New York, 1917. 293 pp.
13. Cardner, Mary S.: *Public Health Nursing*. The Macmillan Company, New York, 1916. 372 pp.
14. Gulick, Luther Halsey, and Ayres, Leonard P.: *Medical Inspection of Schools*. Russell Sage Foundation, New York, 1913. 224 pp.
15. Roberts, E. L.: *Medical Inspection of Schools in Great Britain*. Bureau of Education, Department of the Interior, Bulletin No. 49, Government Printing Office, Washington, D. C., 1916. 69 pp. \$.18.
16. Stanley, A. L.: "School Nursing in Cleveland," *Pub. Health Nurse Quart.*, Vol. V, No. 3, July, 1913.
17. Strong, Anne Hervey: "Some Problems in the Training of School Nurses," *Pub. Health Nurse Quart.*, VIII:88, (Oct.) 1918.
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19. Field, William Alexander: "Civic Control of Public Health Nursing," *Pub. Health Nurse Quart.*, Vol. VI, No. 3, July, 1914.
20. Conway, Genevieve; Rodgers, Elizabeth; Cleveland, Elizabeth; and Martin, Agnes J.: "Cooperation as a Factor in the Work of the School Nurse," *Pub. Health Nurse Quart.*, Vol. VIII, No. 3, July, 1916.
21. Gardner, Mary S.: *Public Health Nursing*. The Macmillan Company, New York, 1916. 372 pp.
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23. Struthers, Lina Rogers: *The School Nurse*. C. P. Putnam's Sons, New York, 1917. 293 pp.
24. American Red Cross: *An Outline for Rural School Nursing Procedures*. National Headquarters, Washington, D. C., 1921.
25. Long, Harvey L.: "What Do School Nurses Do?" *Elementary School J.*, 29:296-302, (Dec.) 1928.

Pennsylvania, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) with 89.4 per cent while the South Atlantic region was lowest with 9.8 per cent in specialized service and highest in generalized service with 73.0 per cent.

In the smallest communities counted, those in group IV, of 2500 to 9999 population, the Middle Atlantic region was highest in specialized service with 84.6 per cent and East South Central lowest in specialized with 5.4 per cent and highest in generalized with 75.0 per cent. East South Central region also has the highest proportion of cities reporting "no provisions for nursing service" (14.3 per cent), New England next (with 13.9 per cent), then West North Central (10.4 per cent), and West South Central (with 9.1 per cent).

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3. National Conference for Cooperation in Health Education, Committee on School Health Policies: *Suggested School Health Policies*. American Medical Association, Chicago, 1945. 46 pp. \$.25.
4. American Association of School Administrators: *Health in Schools*. Twentieth Yearbook. National Education Association, Washington, D. C., 1951. 477 pp.
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6. American Medical Association: *Physicians and Schools*. The Association, Chicago, 1948. 32 pp.
——: *The Second National Conference on Physicians and Schools*. The Association, Chicago, 1949. 56 pp.
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The Nurse's Study of Her School and Community

This study often begins even before the nurse has accepted the position—when she is considering whether to apply for or accept an offered position. If she happens to possess a really inquiring mind, the study may still be incomplete when she leaves the position even though she has held it for many years. There is always something more to learn.

To help her decide whether to accept the position. Of the many aspects to be considered—what it offers in professional status, financial return, geographical location, living conditions, opportunity for continued education, amount of physical exertion required—one nurse will place first what another gives little or no attention.

The nurse who feels that financial return is most important will be wise to take into consideration in determining the financial return certain other factors in addition to the salary offered. What is the salary schedule? What are the arrangements for transportation? Are living expenses high or low? What are the provisions for vacation, illness absence, and retirement, for leaves of absence for study, for stipends? How convenient and economical are transportation facilities between this place and the residences of individuals with

26. American Child Health Association: *Transactions*, Sixth Annual Meeting, Part II. The Association, New York, 1929. 110 pp.
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If the service is used for field work in a university program which is approved for the preparation of public health nurses by the Accrediting Service of the National League for Nursing, she may feel some reassurance. Several days spent visiting the service may help her decide if it offers what she wants.

As she begins her work. If directional and supervisory services such as are described in Chapter 4 are provided the nurse will be given a guided introduction into the service and provided with the information she will need regarding the administrative set-up, her duties, and community agencies with which she will work.

It is for the many nurses who work alone or on small staffs with little direction and supervision that the following suggestions are offered:

One of the first things which must be determined by a nurse in a new position is just what her new employers expect of her. She must clarify in her own mind or in theirs any misconceptions.

The principal under whom a nurse is to work in a certain school may have ideas which have little relation to those of the nurse herself or even of those who employed her—the superintendent or a teacher's committee of the board of education.

She must be sure she understands enough about the school organization to be able to follow the proper lines of authority. By making her own simple and rough diagram of an organization chart as she interviews such administrative officers as the principal, and later the workers of other organizations, she can be sure she has a clear idea if she allows the individual she is interviewing to check it for her. Later information which she obtains from other sources regarding the organization is then built around the first individual she encountered and reinforces her memory.

The "part-time" nurse. Except in the case of a large school, the nurse is usually part time from the point of view of the principal, if not in the mind of the nurse herself, if she has responsibilities outside his own school. The nurse doing a generalized public health nursing program, as well as having her responsibilities in other community health programs, may have some in other schools also. These may be a part of the school system in which the principal's

whom she will wish to spend occasional periods of time? These and other circumstances may affect the total financial situation more than the initial salary.

The nurse who gives first consideration to opportunity for continued education must weigh all the above items and in addition an answer to this question—could she better afford to take another position where she can save more money and be able to go to school full time later? Because of the large numbers of nurses who wish to attend school while working, the salary schedule of certain agencies may be lowered. It is difficult to arrange the work programs of all the nurses so that they can attend classes. If her assignment happens to be at the opposite end of the community from the university, the nurse may find she is unable to carry both the work and college program because of the time and energy required.

The nurse who chooses a certain position because she thinks its demands on her physical abilities will be adapted to her capacities should be sure of her future assignment. She cannot assume that because the nurse who is leaving had a certain assignment, that she as a new nurse will have the same duties.

Determining what a position means in terms of professional status presents difficulties, especially if the position is in a location unfamiliar to the applicant. Advice can be obtained through consultation with state directors or supervisors, members of the nursing staff of the nearest university, and directors of comparable services in the area, to supplement what she learns from the agency referring her, such as a university employment service or the vocational and guidance service of her state nurses' association. If she seeks opportunity for professional advancement, certain facts may be indicative—the number of positions in the organization ranking above the one she is applying for and the policy of the organization in promoting staff members or filling higher positions from outside. If what she wants is professional experience under approved supervision of such caliber that it will not only help develop her abilities but have such status in the professional world that it will mean something on her professional history, she will be interested in the staff education program and in the ratio of supervisors to field staff.

or when there is threat of an epidemic. She may then be paid for the hours, days, or weeks actually worked.

In other situations she may be employed for a regular part of each day, or for certain days of the week, or for certain seasons of the year—perhaps for the physical examinations in the fall or the preschool program in the spring.

Such a nurse meets the same qualifications as those required for the full-time nurse because the needs of the pupils are the same and they are what determine the qualifications.

Transportation.⁽¹⁾ If the nurse is to use a school car, she informs herself of the insurance provisions to see if she is covered for personal injuries and against suit as a driver. She obtains and carries with her directions as to what she should do in case of accident in the way of reporting to school authorities, local officials, and the insurance company, as there are many variations in these requirements. She makes sure she understands the procedure for securing repairs to the car and for having it serviced, and the formalities to be observed in presenting an expense account for it.

For the nurse who furnishes her own car there are two principal methods of reimbursement: (1) a flat monthly rate and (2) a fixed mileage rate for the travel she does for school business. Whatever the method it should be designed to cover in addition to gas and oil used, a proportionate amount of the upkeep—garage, servicing, tires, battery, depreciation, and insurance cost. If the school has a liability policy which covers all employees who transport pupils, the nurse will want to check on coverage for the child's guardian, if she ever takes an adult with the child, and on proper supplementary insurance to cover her nonschool use of her car.

Whether she uses her own or a school car, a mileage record is kept which includes actual speedometer readings correlated with places visited and time notations. This is part of the nurse's own record and as such is available for inspection by school authorities at any time. Usually the expense account she presents is only a brief summary of this detailed record.

When the nurse serves several schools, her travel from school to

school is situated or in another system. A nurse employed full time by the board of education which also employs the principal may be assigned to other schools in that system as well as to his own. Then there is the nurse who is employed by her employing agency for only part of the working day or working week or working year.

There seems to be no natural saturation point for the amount of nursing service a modern school can use to advantage, provided the nurse is well prepared professionally and is the kind of a person whom people like to have around. It is essential therefore that some limitation be established either as to services to be rendered, time to be allotted, or perhaps in terms of what the previous nurse did, so that there will be a frame within which to work out the schedule. (See Chapter 2.)

In the case of a nurse employed for only part time, there may be an additional problem. Because she "has nothing else to do" it may be considered she can change her time of working or continue working beyond the time for which she is employed whenever it might suit the convenience of the situation or other individuals.

Working hours. For the full-time school nurse, specified working hours invariably include the hours school is in session and usually whatever additional time "on duty" is stated for all teachers. Also there is always "unspecified" time required, as for all teachers, in order to meet the obligations of the program—for example, attending meetings outside of school hours or seeing parents who can only be met in the evenings or on week ends.

The part-time worker may expect to give and may be expected to give some overtime but it is logical to keep this in proportion to the amount of time for which she is employed. If, for instance, she is employed for half time, the overtime might be about one half as much as is usual for full-time employees.

The basis for the employment of a part-time nurse may be that she will be available at irregular times. These may be when the physician is free from his private practice responsibilities so he can make the examinations, or when immunizations are to be given,

problems; there are possibilities of working through one family to another in some instances.

Periodically she can make a quick evaluation of the progress she has made toward reaching all the families in her community.

Use of map in developing parent groups. Today in many different parts of the country, progress is being made in organizing large rural school districts made up of a number of small ones which previously operated separately. A valuable activity of such large schools is the adult education programs offered. Certain parents readily come to the school to participate for these and other activities. Others who are often the ones in greatest need of the help offered by group instruction hesitate to come to a new and perhaps distant center. Nurses working in such new school organizations have found it possible to organize some of these people in small groups to meet with someone from the central school for discussion of certain problems in which they already have an interest. Then later they can be drawn into more formal classes which utilize the facilities of the high school building.

Aspects of home nursing will be attractive to the small "first" groups who meet locally made up of mothers or older girls who have left school. The nurse can offer a series of informal classes on a very simple basis, including child care, prenatal care, how to prevent communicable diseases, and related subjects. By studying the map the nurse and principal can tentatively select a number of areas in which such work is needed. They then look for a suitable person in each to act as a leader in getting together from six to a dozen local women, in having them decide what topics they would like to discuss with the nurse, and when and where they will meet. The place selected may be the former school or other public building but often is the home of one of the group.

Meeting several times with such a group does a great deal to acquaint the nurse with family and community problems which might come out much more slowly in individual conferences. Her area of personal acquaintance increases rapidly through this means also.

school is included. Arrangements made when she is employed determine whether her travel from her home to her first school and from her last school to her home are to be included.

If buses and streetcars are available, fares paid by the nurse may be refunded to her at intervals as she turns in an expense account, or as with a car, a flat rate per month may be allowed for the purpose.

School boards find that the most expensive transportation the nurse can use is walking, and when public facilities are inadequate and only a small amount of transportation is needed, taxi service is provided by an increasing number of schools.

A map. Whether the new nurse's assignment is in a city, village, or rural area, she will want a map. The school system may be able to supply her with one. In a city the chamber of commerce is another possible source. For rural areas, the county road engineer may be able to give her one or refer her to a source. In a village she may have to construct her own; or the social science teacher may be interested in supervising her pupils in constructing one for the nurse.

When the school includes pupils who come from without the school district in any considerable number, the map of the village itself should be started on a paper large enough to allow for later inclusion of surrounding areas from which outside pupils are apt to come. These pupils can then help add the necessary roads and locate their homes on the map.

Public transportation facilities are indicated on the map, for even the nurse who uses a car needs to be familiar with them to help pupils and parents in planning for obtaining treatment.

The new nurse will find many uses for the record if she marks on her map the homes she visits, identifying each by a number on the map and listing the numbers on a card with the name of the family and the date visited. Besides fixing in her memory the location of the home, it helps later to identify the road for her. It will prove a help when she plans later home visits; neighborhood associations are suggested to her when dealing with children or family

Another section of the file consists of cards listing the classroom rolls of each class in the school, with the index number referring to the child's family card after each name. This must be remade each year.

Another section may consist either of cards with an alphabetical list of all the children on the school census, or of a separate card for each child. In the first case, the lists must be remade each year. If the second method of separate cards is used, only refiling is necessary with some cards withdrawn, and new cards made for new names on the school census, with the new room location of each child noted on his individual card.

Since this directory contains no confidential data but is truly just a directory, volunteer clerical help or even student help may be used to set up and maintain it. If only the nurse were to use such a file the time and effort required to establish and keep it up to date might be questioned. But other staff members find it equally valuable—census taker, attendance worker, principal, classroom teacher, guidance worker, visiting teacher, and clerks. It locates a child in the school and places him in his family group.⁽²⁾

"Learning" the pupils. The nurse usually will find this easier to do on an individual basis than on the classroom group basis. She will find her progress facilitated in this big undertaking if she makes it a practice never to talk to a pupil without identifying him before she gets through. If he does not bring a referral slip from his teacher with his name on it, she asks him who he is and from what group. Calling him by name as she talks with him is not only good manners and a friendly gesture but helps her to remember him. While she still has his appearance and personality in mind, it will help, too, if she can take the time to look him up in the family file to associate him and the problem he brought to her with his parents, his place of residence, or some of his brothers and sisters. Reference to his medical record is likewise helpful in establishing his identity in her mind.

Each time the nurse visits a classroom she may make it a point to identify at least one more child than she knew before.

With a load of 1500 pupils the nurse is usually able by the

For raising the level of living in the community, the nurse is interested not only in what she herself will teach but in stimulating other classes such as nutrition, cooking, home repairs, and gardening. It is possible for her to drop in on any of these groups and meet the various members.

"Learning" the families. Of course in the nurse's study of her school and community, the people—the pupils, their families, and the teachers—are her most important subjects. They in turn should have a chance to learn to know *her* on an informal friendly basis. This involves the nurse becoming acquainted with from 500 to 2000 pupils, from 20 to over a hundred teachers, and from 200 to 1500 families. This acquaintance will lose its superficiality more quickly as she bases it on information already available in the school. Its value will be greater to the school if she arranges so that other school workers can profit by what she learns of these people.

A family directory. This may be arranged in card file, book, or folder form, but there is hardly a school without some sort of a listing of children by families.

A card file is simple to operate. In one section there is a card for each family filed under the name of the "head" of the family. Included on it are mailing address, directions for reaching the home, telephone number, how parents may be reached when at work, in the case of broken homes or foster parents names and addresses of absent parents, listing of children on the school census, with dates of birth and names of schools attended by children not in this school. Children living in the household and attending school are noted even though not members of the family. On this card also may be noted the date of any conference at school or in the home with a parent and the initials of the staff member who conferred. This allows the worker who is going to approach the family next to look up the record of previous conferences and go on from there if she wishes.

A valuable supplement to this section is a listing of the families by roads or neighborhood areas.

There is an alphabetical list of the families with index numbers.

situation as they did in her previous use of them, or in the situation where she observed them, or as perhaps they were presented in a book she read.

Information regarding many school practices is naturally only accumulated over a considerable period of time. But as soon as the nurse is on duty she may be called upon to meet an emergency. Before school opens, therefore, she obtains information regarding the general policies and principles for emergency care set up for the school. Also she familiarizes herself with all the details of standing orders and instructions for care of emergencies. She inventories the equipment and supplies for first-aid care and requisitions additional materials needed.

Making such a review before school opens gives an opportunity to try to remedy the situation if she finds policies have not been established. (See Chapter 2.)

The school calendar. If a school calendar is part of the manual furnished to teachers or parents, the nurse will use it as a nucleus and add items of significance in her work. If no calendar of school events is available, she will construct one for herself, beginning with such events as school holidays, and the dates for school tests, examinations, and special programs, so that she may avoid these in scheduling her own special programs of testing and medical examinations. She will obtain from the physician any interruptions he anticipates in his schedule. Tentatively she will enter dates of professional meetings she should attend.

If the school sends periodic reports to parents she will note the dates of such mailings so she can enclose material if desired. The dates material should be completed for inclusion in form letters, school paper, or local newspaper are also worth noting.

If she plans on sending "reminder notices" (see Chapter 10) to parents who have failed to respond to messages regarding medical attention for their children, she may note on the calendar that they should be sent a few days before a vacation or a long week end. The fact that school is not in session may offer a special impetus for the parents to arrange care during that period.

close of the first year to recognize all the children's names when she sees them and by sight to identify at least half the children by family name if not given name.

"Learning" the teachers. Whether full or part time, the nurse will find herself repaid by saving in time, confusion, and embarrassment, if she uses whatever time is required to memorize from the faculty directory, the names (including proper spelling), room location, and subject or grade assignment of each teacher. It is then much easier to fit the identities to the individuals as she meets them. She will hasten her acquaintance with the group if at the end of each day she checks over the directory list and calls to mind the appearance and personality of each one with whom she has had contact that day. At the same time she can make a mental list of those she has not yet met and make an effort to find them. At the end of the first month unless her load is unreasonably large, she will know her teachers.

Becoming familiar with present school practices. A review of the previous nurse's reports and a study of blanks and forms used will supplement what the nurse is told by the administrator and teachers, if there is no manual of procedure for her to study. Attendance at faculty meetings will help the nurse gain familiarity with policies and procedures.

Among the values expected of a new staff member are a fresh point of view and new ideas. In presenting suggestions the new nurse will find a better chance of securing a hearing if she harmonizes them with current practices as far as possible rather than gives an impression of overthrowing and discarding what has gone before. If she offers fair recognition to what has already been done and builds on previous accomplishments her ideas will be more readily acceptable to the established group.

Usually the nurse finds it wise to wait to make suggestions for any radical changes until she has given a thorough tryout to the established methods for a reasonable length of time. One advantage is that she can then gather pertinent local evidence as basis for the proposed change. A more important reason is that she often finds the changes she had in mind would not work as well in this

participation in its affairs one method of "learning" the teachers.

Comparison of the methods of functioning of teachers' organizations, on local, state, and national levels, may give her some good ideas to take into her nursing organization work.

Parent-teacher groups. In almost every school today there is some sort of a parent-teacher cooperative group with a more or less formal organization. If it is part of the National Congress of Parents and Teachers the nurse may already possess a working knowledge of its general aims and methods of procedure. However, even within this framework there are many variations possible so she will refrain from making what may prove to be wrong assumptions and take time to become familiar with the local arrangements. For a while she will function merely as a working member leaving leadership to those already informed.

Because of the nurse's concern with health she may be offered the chairmanship of a committee functioning in this field. It may be wise for her to point out the advantages of a lay chairman, since her own services and participation are already assured.

State laws and community regulations which affect school work. If the state is one in which the nurse has not worked previously, she will need to study state laws and the regulations of state departments of health, education, mental hygiene, welfare, and labor as they affect school children and schools.

If the community is within the jurisdiction of a regional or county health department, she will ascertain its applicable regulations.

Finding time to study the community. Too rarely does the nurse have time set aside for this purpose. Usually it is a case of snatching a few minutes here or a half hour there when an opportunity occurs for her to add to her knowledge of the function of a cooperating individual or of the operation of a certain agency in the community. During her first few months in a community it will help if she takes time occasionally to make a few notes on what she has learned so far, and perhaps to make an informal list of some of the things she would like to find out about.

Defining her "community." The nurse often finds that the school district is not coterminous with any city, village, or town

"Learning" the school plant. Some time before or during the first week the nurse will wish to get at least a bird's-eye view of the school buildings and grounds which are to be included in her responsibilities. If it is possible to schedule so early the sanitary survey, described in Chapter 6, which she will make with the school physician, administrator, and building superintendent, it will give her an ideal opportunity to familiarize herself with the general layout and the special problems of environmental health.

If this survey must be deferred, she can make a preliminary inspection by herself, perhaps incorporating in it interviews with some of the key people on the staff who have special areas of the plant as their particular responsibility—for example, the directors of shop, physical education, music, home economics, and visual education. The building superintendent may appreciate an opportunity to explain the heating, ventilation, and cleaning systems to her.

Unless the buildings are all in one unit she locates them on her map.

Teacher organizations. Here the nurse employed by the board of education may have a relationship different from that of another nurse assigned to the school work. Any nurse working in the school program will familiarize herself with any teachers' organizations there are as these may offer opportunities for her to approach the teachers in a group. This may be especially desirable if she finds that too little or no provision has been made for teacher medical examinations or for hospitalization plans. Also some such organizations have committees on teacher welfare, some on pupil welfare, and on various other projects with which the nurse may be concerned.

Health program for school employees. The nurse employed by the school board, herself an employee, will have a firsthand opportunity to learn the requirements and provisions for health examinations, hospital insurance, provisions for sick leave, and other related features. She and any other nurse doing school work may have responsibilities in carrying out the health services for employees.

The nurse eligible for membership in this group may find active

type of a survey report—agricultural, political, industrial, or what not—she can learn something of the community and of what goes on in it.

Much of the information a nurse would like to have is often not available anywhere, but certain facts can be found if she knows the right places to look. The clerk of the school board, the city clerk, and the county clerk can direct her to some sources, such as those for the property evaluation of the district, the school tax rate, and other tax rates. The district office of the state employment service can supply her with or direct her to general information on such subjects as the economic and industrial situation, the proportion of women working and in what occupations, amount of unemployment, average income and typical wage scales, various rent levels, and amount of home ownership.

The health department through its local, county, regional, or state office can give her figures on mortality, morbidity, and birth rates. Through the same office or that of agriculture and markets, there may be figures available on the amount of milk consumed. In an urban area, the wholesalers, the chamber of commerce, and the food inspectors are possible sources of information regarding consumption of certain foods, while in the rural areas a farmer's cooperative might be approached. Such information need not be gathered routinely but might be sought when a special effort is to be made to improve food habits, in order to be able to measure progress.

Community history. The social studies teacher and the school and local libraries are possible helps in learning something of the social, economic, political, and religious history of the community. Usually it might be more accurate to put history in the plural and say: "histories of the various segments that make up the community," for whether the school district is a small section of a large city system or an extensive rural area, it is often found to be made up of a number of small subcommunities, each with a history and background of its own. In many instances such a mixture is present that the nurse can have no hope of learning all she would like to know and could use concerning the many cultures represented.

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lines. It may even include parts of more than one county. Her first problem may therefore be, as with transportation, to obtain, make, or have made a map to help her clarify her understanding of the boundaries. The school will have a map but she may have to make her own copy.

It is important that she identify the lines bounding the various political subdivisions included in the district as they usually mean she must consult different officials when families have health or welfare problems. Special water or sewage districts are also worth noting.

The general population in the district as well as the school population is of interest to her, also the number of square miles in the area covered by the district. Such data are needed to compare resources of the area with established standards or with those of other communities.

On her map she notes ponds, lakes, creeks, as well as rivers and even ditches which may fill with water at certain seasons and become safety hazards for young children in addition to being possible health hazards for all. Play spaces, officially assigned or appropriated by the children are entered. Railroad and bus stations, flying fields, and boat landings are located as points of entry and departure and also as possible gathering places for youth. In every community there will be other physical features of possible significance which she includes in her picture.

Sources of information. The government census affords information of some value to her if she is able to apply it to her small group. The latest issue of *The World Almanac* ⁽³⁾ offers a great variety, but here again she must break it down to the particular situation and that may prove hard to do. Although she will lack time and opportunity to make the type of study described in it, Colcord's *Your Community* ⁽⁴⁾ will help her know what to look for and suggest sources for further information about special aspects of such a study.

The nurse will inquire whether the area has ever been included in any sort of a survey. Of course surveys in the fields of health, education, or welfare would interest her most, but from almost any

type of a survey report—agricultural, political, industrial, or what not—she can learn something of the community and of what goes on in it.

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The essential thing is, and this is within her range of accomplishment, that she recognize that there are great variations in cultural backgrounds and not attempt to impose her own pattern upon the children and their parents nor expect that they will all conform to any other one pattern.

A continuous utilization of each opportunity to add to her knowledge of the details of the many cultural backgrounds whenever she is working with individuals of special racial, national, and religious groups to whom they belong will vitalize her work with them and increase her enjoyment.

The school nurse and voluntary agencies. The nurse's relation to these groups is bidirectional. She depends upon them for many services and for a great deal of assistance which pupils and their families need and which is either not available or is unacceptable from public agencies. In the other direction she, as a citizen of the community with a more than average appreciation of the value of efforts for community improvement, may be expected to and may wish to participate in their organization and maintenance.

The nurse often makes a special use of voluntary health groups dealing with handicapped children. If the parents of such children, and sometimes even the children themselves, associate themselves with the work of the voluntary group, they receive therapeutic help in acceptance of their individual burdens through the objective viewpoint obtained and the experience with others having similar problems.

The 20,000 voluntary agencies supported by gifts of \$100,000,000 annually have 300,000 men and women serving on their boards and committees.⁽¹⁾ Services and material available from some of these organizations are described in Chapter 11.

During the period of great growth in voluntary agencies occurring in the past half century, the force back of them has resulted also in the spectacular development of nursing services in the school. Part of it is the American desire to help the less fortunate; another part is the equally American desire to improve conditions under which we are living. In the case of school nursing these desires are

carried out through laws and tax money; in the case of the voluntary agencies a more elementary democratic method is used of planning, supporting, and acting without laws to force action or tax money to support it.

The groups are made up of the professional and nonprofessional, the wealthy and the wage earner, those with leisure and others with little time but much determined effort, those who join because they understand the facts underlying the situation, and others because they are moved emotionally.

Because of their free growth in response to social and emotional interests in communities, there are naturally inequalities of support, overlappings, and omissions in meeting the needs of the people in most communities. The nurse then is one of the professional workers in the community who sees the value of an over-all planning group in the community, made up of representatives of these organizations and of the official education, health, and welfare agencies.

Building a file of community organizations and workers. Perhaps someone in the school system, the preceding nurse, the present attendance worker, or the principal, has already set up such a file or notebook. If not, the nurse will start it, but it will help if she interests others in developing it as well as in using it after it is established. It, like the study of the community, is the type of activity which is never "completed." It must be constantly revised as workers change; it must be added to as organizations develop new projects or drop old ones; new organizations are listed as they are developed.

If there is a council of social agencies, a community chest with a committee on health and welfare, or a community health council, the nurse may well follow any directory issued by such a group in setting up her file headings. Under one heading or another the following general groups of agencies and workers will be listed:

WELFARE AGENCIES. Because the school does not, and should not, give material relief, and because the nurse in the nature of her work encounters situations where material relief is needed this will be an important section of her file. It will include official and volun-

tary agencies. It may include individuals who are interested in helping when certain types of problems are present.

For each organization the standards of eligibility for giving help are noted.

TREATMENT RESOURCES. Medical treatment may have many subdivisions under it, such as tuberculosis, orthopedic, cardiac, ophthalmological, otological care.

Dental treatment may include a special listing for orthodontic treatment.

Treatment facilities for nutritional problems and for mental and emotional difficulties are other important headings.

For those conditions where local facilities are lacking, state and even national agencies may be included. (See Chapter 11.)

Included also are the names of individual practitioners who are willing to be called upon when help is needed.

SPECIAL INTEREST GROUPS. Here will be included local branches or chapters of such organizations as the National Foundation for Infantile Paralysis, American Heart Association, American Social Hygiene Association, and whatever other groups there are in the community. Local groups may be supplemented by regional or state organizations as is the case with the Society for the Prevention of Blindness and the American Hearing Society.

Also listed are groups with a special interest in some particular handicap, or in a milk fund, or in providing school lunches, or shoes for school children.

PROFESSIONAL GROUPS. They will include groups of nurses, physicians, specialists, dentists, physical therapists, optometrists, and any other groups of recognized professional workers.

CHARACTER-FORMING YOUTH ORGANIZATIONS AND RECREATIONAL POSSIBILITIES. In a highly developed community the nurse may find it desirable to list these two groups separately but in a simpler situation the one grouping may be enough.

FAMILY GUIDANCE AND FAMILY SERVICE. In many communities there may be no organizations specifically designed to give such help. But some informal help may be available through church or other organizations as an outgrowth from another program.

PRESCHOOL AND PRENATAL SERVICES. The nurse's study of these facilities should be unusually complete and made as early as possible, so that she may participate in efforts to strengthen any services which are weak or lacking.

LEGAL AGENCIES.⁽⁶⁾ The school is not a law enforcement agency but its workers learn of situations where children need the protection the community has provided for them through its laws.⁽⁷⁾ The file then includes information concerning enforcement officers on different levels—justice of the peace, children's court, state police, and federal agents, specifying the types of occasions for which each is consulted.⁽⁸⁾

The legal advisor for the board of education is listed.

If there is an agency which furnishes legal aid to those unable to pay, the nurse will list it as she may find parents who should be referred for such help. When there is no such agency, there may be certain lawyers who are willing to be called on for help.

In states where a state parole officer is assigned to each area his name, address, and function are entered.

RELIGIOUS GROUPS. A special listing under this heading may or may not be needed as religious agencies will already be listed under other headings according to services they offer.

Preparation of a directory by a group of nurses. Nurses working in the same general area, such as those within a county, have found that they can save time and obtain a more helpful directory by working together in developing one.⁽⁹⁾

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PART II

*Planning the Work of the Nurse
with School Age Children*

*Selection of the Nurse: Her Personality,
Education, and Professional Preparation*

The kind of a person who makes a good nurse in a school. A nurse working in a school health program can put to effective use practically any unusual skill or talent she may possess. Ability in writing, dramatics, public speaking, art and music, in leadership, in political or social organization, personal charm—all can be utilized to good advantage in one way or another.

Success in school health work, however, is based on less spectacular but essential characteristics. As a person the nurse must be independent enough to accept whatever responsibility she must carry in a school situation. Yet her sense of independence must not be so strong that she will be unhappy when others know more about the particular matter than she does. At times she must depend for direction upon the administrator or teacher and sometimes on the parent. Her basic sense of security must be so well established that she will not be upset by natural feelings of inadequacy in the many new situations she encounters.

She must have learned to manage the tendency we all have to resist change. In the school environment she will be obliged to think and act quite differently than she was taught to do in the hospital. Instead of setting up in the school a "little hospital" in which she carries on as she did in her school of nursing days or

gram, it is only one part and must contribute to and receive contributions from other parts. She must see that while the school health program is an essential feature of the community public health program it also must contribute to and receive contributions from other parts or it is not functioning properly.

The nurse selected for school work should not be immature; neither should she be an exhausted person who thinks of her work day as being as short as the pupil's day and therefore restful. The nurse who meets her responsibilities in a school program has an exacting and heavy program. In addition to the physical, emotional, and mental reserve needed to meet the emergencies which arise, she will need an additional energy margin to continue her education while she is working. Health and educational research move ahead swiftly. The nurse also must move rapidly if she is to keep in step.

Her personal health practices must be excellent. In order that pupils, parents, and teachers may feel the sincerity of her health teaching she shows proper health attitudes and practices in her appearance and manner of living. For her own protection as well as an example to others she has an annual health examination, supplemented with more frequent checkups when indicated and with a complete follow-through on her physician's advice to correct any defects or undesirable health practices.

She does not attempt to work when ill.

The nurse's field of knowledge. The work of the nurse in the school health program requires her to acquire and synthesize information from many areas of the physical and social sciences. More difficult still she must know how to apply diverse information to help in solving many types of health and social problems of pupils, parents, and teachers. Skill of even greater degree must be used to help these same individuals to learn how to use comparable information and methods in solving their subsequent problems. The nurse must understand and be able to apply knowledge of child development and health to the child in his home, school, and community situations and help others to do likewise. She must know and be able to utilize principles of education and school administration to work out constructive school health procedures. She must

know and apply public health principles and those of public health administration to school situations. She must know appropriate principles of social work and possess the ability to integrate them into the school's procedures for dealing with child and family social problems. Her knowledge of environmental sanitation and the hygiene of daily living must be so much a part of her that she is quickly sensitive to undesirable variations from safe standards. She must be quickly aware of and understand emotional and social atmospheres in school and homes. She must not only know community resources—health department facilities, well-child clinics (public and private), and public and private hospitals—she must know health facilities for those who can pay; she must know welfare, recreational, legal, and religious resources; also she must have good judgment in her choice of the particular resource which can be used to help the individual.

The nurse's field of action. Through her work in the school program, the nurse participates in carrying into the lives of the children and their families the objectives of both the school and the health department. Preparing the nurse to implement these two sets of objectives may not be as difficult as it sounds. In *Social Services and the Schools* ⁽¹⁾ The Educational Policies Commission describes the services rendered by these two community agencies as follows: "Public School Authorities—Guidance of the intellectual, moral, physical, and social development of the individual (for minors and some adults); Public Health Authorities—Protection of health and protection from health hazards and environmental dangers (for the total population)."

It is obvious that a nurse carrying on activities designed to realize objectives of one of these agencies will, in the process, contribute to the realization of objectives of the other agency at the same time.

The objectives and activities of a third community agency are also involved in the work a nurse does with and for school children and their parents. The Educational Policies Commission describes these services in the same publication: "Public Welfare Authorities—

Amelioration of the circumstances of individuals (for defectives, dependents, indigents, and maladjusted)."

So closely interwoven are the objectives and activities of these three public agencies that it is necessary, when a community is properly supplied with workers from each, they plan together in detail the correlation of their work together and also with other official and private agencies and individuals concerned with welfare, health, and medical care in the community. In a community where only one of these agencies has a worker established, it is inevitable that the worker carries some responsibilities in the other two areas, in order to properly meet those in his own. Of course, these "borrowed" responsibilities are met on a different level of service from what they would have been by a representative of the agency itself.

Therefore the nurse employed for school work, even if she is not an employee of the health department, must be well grounded in the functions and methods of the health department if she is to be considered well prepared for school nursing. Both she and the nurse employed by the health department and assigned to school work need in their preparation to acquire enough understanding of welfare and social work to enable them to coordinate with and supplement when necessary services for children in the social welfare area. This does not imply that the nurse in the school becomes a professional social worker any more than her study of chemistry in her basic nursing education makes her a professional chemist. As a nurse she is already a field worker in the practice of social science; as a public health worker her function as a social scientist is intensified. Historically, the nurse in the school implemented one of the earliest of society's attempts to apply the findings of social science to improve the actual living of some of its members.

The school nurse as a practitioner of social science. Chase (2) recognizes as the "hard core" of social science five disciplines: cultural anthropology, social psychology, sociology, economics, and political science. The need for sociology and social psychology in the preparation of the public health nurse has long been recognized. There is a growing recognition of the value of the other three. The

problem of how to include them or any other additional material in the all too limited time of preparation available would be unsurmountable were it not for another trend which Chase also mentions: "The lines between them [the five disciplines] are beginning to melt." If it were not for such melting between the disciplines which contribute to basic nursing education, there would be an impossible situation. Integration of health and social aspects of nursing into the already established curriculum is an illustration of possibilities along this line. Some material previously required in the public health nurse's postgraduate work is now unnecessary as it is included in the basic curriculum.

In an earlier day the school nurse often asked in her postgraduate work for courses in public speaking, writing and presenting reports, and participating in and leading group discussions. Now students come into the schools of nursing with practice in such activities not only from their secondary school experience, but some even from elementary school. This makes room in their professional preparation period for advanced work in specialized areas, on a professional level.

Other factors affecting the preparation needed. Nursing services needed by a school child are the same whether the nurse is employed by the school or the health department. Her preparation need not be discussed in terms of her employing agency, but there are other factors affecting the extent if not the type of preparation required.

One such factor is the intensity of her work in the school situation. The time available for school work may be sufficient so that the nurse becomes an integral part of school life. She works on curriculum committees. She acts as consultant for discussion groups which may range from those in the kindergarten to high school and adult education classes. She gives a great deal of direct health guidance to children as problems in healthy living arise during the school day. She is readily accessible to teachers and administrators to advise on many details of hygienic school living. Such a nurse makes much more use of a broad and deep background in education than might the nurse whose work for school children

sively used as the teaching method. Continuous study, research, and experimentation are required to improve the selection of situations in which to place the student to ensure the best learning experiences and properly graduated levels of responsibility. There has been too little of this in the school nursing field.

For the nurse preparing to do any type of public health nursing, school experience, if carefully planned, can give opportunities for development of certain desirable concepts and skills less easily available in other fields of public health nursing. The emphasis on positive health is greater. Seldom are such broad cross sections of the community included in a public health service. There is unusual opportunity to study coordination of a great variety of community agencies. Observation of successful teaching methods and opportunities to participate in teaching projects are more easily available than in most public health nursing work. (See Chapter 22.)

Improvement is needed also in administrative arrangements for employment of nurses for school work. There should be more opportunities for prepared but inexperienced nurses to obtain real work experience under good medical direction and nursing supervision before assuming the difficult responsibilities in positions where they are employed as the only health and welfare worker in the community. There seems little prospect that the number of such positions will soon diminish. In fact adding a nurse to the staff is still only a dim hope in far too many schools. In many other communities for some time to come the nurse will continue to be the only worker offering some "social engineering" to school children in many sections of the country.

However, there is hope that as rural schools combine in larger administrative units and more county health units are established, greater opportunities will develop to organize the nursing service for schools in such a way that student experience can be arranged and inexperienced nurses obtain desired work experience under proper direction and supervision.

Establishment of standards for preparation. Recommendations have been made by many official and professional groups concerning desirable preparation for the public health nurse in the

school. While there has been no general agreement on any one statement, differences between them are less in the concepts upon which they are based and more in the terms used and details included.

In the material which follows certain similarities in fundamental principles are evident, as for example:

1. The nurse must have state registration and be currently registered as a professional (not a practical) nurse.

2. Her basic nursing education should have been the best available—with broad clinical experience in medical nursing including acute communicable disease, tuberculosis, and venereal disease; psychiatric and pediatric nursing including care of children with orthopedic and cardiac conditions; and an understanding of the social and health aspects of nursing, both physical and mental, through an integrated program of instruction in classroom, ward, and outpatient department, with appropriate use of community facilities.

3. This basic training should include or be supplemented by completion of the program for the preparation of public health nurses approved by the National Nursing Accrediting Service. This should include or be supplemented by courses in the organization and philosophy of education, health education, and school health services; in human growth and development with special attention to children of all ages; techniques of counseling; and correlating field work in school situations.

4. The nurse must have the equivalent of a high school education. It is desirable for her to have a bachelor's degree. A master's degree is an advantage.

Statement of standards by committee of the World Health Organization. The expert Committee on School Health Services of the World Health Organization in its "Report of the First Sessions" (3) says:

. . . 4.3.2. *Nurses.* The nurse, like the physician, has a different type of task when she works within the framework of the school, for it is not the clinical situation to which she has been accustomed in her hospital experiences. It is a new kind of experience, one with children, to which the nurse must bring warmth, acceptance, and understanding. To the teacher she must be a source of information and guidance. To the parent

she must be a friendly counselor—cognizant of community resources, sympathetic with family problems, and an interpreter par excellence of the child's needs as revealed by medical examinations and school behavior.

The nurse, then, has many roles to play, and she must be well qualified by training in many different aspects of the work. First, she should be a fully qualified nurse and registered in her own country. She should have, in addition, preparation in public-health nursing, such preparation to include courses in psychology, mental health, health education, and the understanding of behavior, as well as a good background knowledge of child growth and development. Furthermore, she should expect, when employed, to work under a qualified nurse supervisor.

The precise preparation required of the public-health nurse needs further close study, and the Committee recommends that this be undertaken.

In those countries where there is a great shortage of qualified nurses it may not be possible to secure nurses with the above qualifications for school health services. In such cases the best prepared nurses available should be utilized. These countries should make every effort to develop schools of nursing in which the principles of mental health, public health, and prevention of disease are integrated into the basic nursing curriculum. In this way all nurses will be better prepared to carry out their function of teaching positive health to both the children and their families.

Where it is necessary, and desirable, to use auxiliary nursing personnel in the school health service, they should function under the supervision of a well-qualified nurse with public-health preparation where possible.

School health procedures are ever changing. Thus the nurse, as other health workers, must have the opportunity to improve her professional qualifications. This may be achieved in many ways, through planned educational staff meetings, attendance at vacation institutes, or short term conferences.

National statements. There are a number of national groups interested in improving nursing service in schools. These include nursing groups, public health groups, educators, school administrators, and those colleges and universities concerned with the preparation of public health nurses. Among the national bodies which have defined at various times what they consider the prepara-

tion should include are the National Organization for Public Health Nursing, American Association of School Administrators, Joint Committee on Health Problems in Education, National Conference for Cooperation in Health Education, American School Health Association, and the American Public Health Association.

Standard set by the National Organization for Public Health Nursing. From the time of its organization in 1912, one of the chief concerns of NOPHN has been better preparation for the nurse engaged in public health work. Its Education Committee worked closely with the Committee for the Study of Nursing Education, appointed by the Rockefeller Foundation in 1919, which included in its report the statement that public health nurses as well as superintendents, supervisors, and instructors of nurses should "in all cases receive special, additional training beyond the basic nursing course."

The organization's School Nursing Section created in 1920 has bent its efforts specifically toward a continuing study and review of the educational opportunities for the preparation of nurses for school work and suggestions for their improvement.

Periodically, the organization has issued statements on qualifications for nurses working in public health. In the 1926 edition of the *Manual of Public Health Nursing** this definition of qualifications included:

The nurse should be a graduate of an accredited school of nursing, which provides theoretical instruction and experience in medical, surgical, pediatric, and obstetrical nursing. General education equivalent to a high school course is highly desirable and should be required where local conditions make this possible. The nurse should not undertake work alone without special preparation for the public health field obtained either by a postgraduate course or by experience in an organization offering educational supervision. Nurses should be registered in the state in which they work.

In the same volume in discussing the principles of school nursing this additional statement is made:

* National Organization for Public Health Nursing: *Manual of Public Health Nursing*. The Macmillan Company, New York, 1926, p. 21.

As an integral part of a progressive educational school system, school nurses feel the need of additional preparation for their work. Suggestions as to courses of study to pursue may be obtained from the National Organization for Public Health Nursing.

In the new structure of the merged national nursing organizations set up in 1952, the function of standard setting for the preparation of the nurse for school nursing is assigned to the appropriate committee of the section concerned with these nurses which is a part of the new American Nurses' Association.

The most recent statement of the National Organization for Public Health Nursing, quoted from the August, 1949, issue of *Public Health Nursing* is:

A review of the abilities needed to carry out the functions [of the nurse in the school health program] reveals that the nurse, in order to fit into the school health program, must have an understanding of child development, educational principles, and school administration.

Inasmuch as nursing services offered the school age child are an integral part of total public health nursing services, the nurse in the school should be prepared in public health nursing. The nurse entering the field of public health nursing should first be a well prepared nurse; she should have state registration, and although the baccalaureate degree is not a requisite, it is desirable.

After analyzing the children's health needs and the functions of the nurse to meet these needs the Committee [NOPHN School Nursing Section Committee on Qualifications of the Nurse in the School] recommends either that the nurse in the school be a graduate from a university school of nursing preparing for public health nursing positions under qualified supervision . . . or that she complete the program of study in public health nursing in a university accredited by the National Organization for Public Health Nursing. Preparation for work in the school should include courses in child growth and development, school organization and administration, nursing in the school health program, guidance, principles and methods of group health instruction, and two months field work in a school situation or in a school health program where the public health nursing services are rendered through a generalized public health organization. These courses may be planned as

part of the program of study in public health nursing or the baccalaureate degree program.*

Annual studies of the actual preparation of public health nurses in the various states and working in the different fields of public health nursing, made by the United States Public Health Service as part of its annual census, indicate that much progress is necessary before these standards are reached in the majority of states.

Standards recommended by the American Association of School Administrators. In its 1942 Yearbook *Health in the School*,⁽⁴⁾ the association quotes the recommendations of the National Organization for Public Health Nursing current at that time and recommends that school nurse work be included in the experience requirement. For the nurse supervisor, a college degree with courses in education is stated as an essential and preparation in the theory and practice of supervision as desirable.

Recommendations of the Joint Committee on Health Problems in Education. This is a joint committee of the National Education Association and the American Medical Association. In various studies and publications it has considered the functions of the nurse in the school. In 1939 the committee published *The Nurse in the School* ⁽⁵⁾ in which reference is made to "Minimum Qualifications for Those Appointed to Positions in Public Health Nursing" which was the current statement of the National Organization for Public Health Nursing regarding preparation. The committee makes this comment concerning it: "These qualifications should be thought of as initial steps to be taken before appointment, and to be supplemented regularly by further preparation in the fields of health and education."

Recommendations by the National Conference for Cooperation in Health Education. In its publication *The School Administrator, Physician, and Nurse in the School Health Program: Functions and Education*,⁽⁶⁾ † the conference includes in its descrip-

* D.J.worth, Lula P.: "The Nurse in the School Health Program," *Pub. Health Nursing*, 41.8, 1942

† Courtesy of the Metropolitan Life Insurance Company.

tion of education for the nurse serving the school the qualifications set up by the National Organization for Public Health Nursing but adds:

Her preservice educational experiences should help the nurse to develop a well rounded personality while she attains the insights, understandings, attitudes, techniques, and skills which will be demanded by her professional service in the school.

Special preparation should be provided for the nurse to supplement her instruction and training in basic nursing and in public health nursing to the extent necessary to insure the following abilities:

- To understand and work with well children
- To acquire sufficient understanding of educational administration and educational methods to be able to work in the school as an integral part of it
- To use tests and measurements of health status
- To instruct and supervise others in using such tests
- To correlate results of health tests and measurements with standards of normal growth and development
- To instruct and supervise in the application of health appraisals and health observation techniques
- To interpret to teachers the importance of medical follow-up and the use of records in relation to follow-up
- To advise teachers in achieving and maintaining the best possible environment. This requires knowledge of school sanitation and other environmental factors affecting children's health and the ability to interpret them
- To employ health education techniques as she renders service to children, teachers, and parents
- To participate in the health education of teachers and parents both individually and in groups
- To interpret community health resources to school authorities and to assist school personnel in utilizing them
- To interpret school health objectives to parents and to assist them in achieving a carry-over into the home.

These special requirements may be met in a variety of ways. For example:

By broadening the basic nursing and public health nursing training in certain areas

have been made by Lula P. Dilworth, Assistant in Health Education, Division of Health, Safety and Physical Education of the New Jersey State Department of Education. Studies were made in 1931, 1937, 1941, and 1949.⁽⁸⁾

As might be expected from the numerous variations on the national level, there is great diversity of standards in the states. They vary from a minimum requirement of "registered nurse" to a bachelor's degree including or supplemented by the preparation in public health nursing approved by the National Nursing Accrediting Service.

Legal authorization for school nursing. Thirty-two states reported in the 1949 study, a permissive law; 15, no law; and 1 state did not report.

In the 1931 study only 11 states were found which required certification of the school nurse; by 1949, this was required in 20 states. New York and Pennsylvania had been the earliest, establishing requirements in 1920, Connecticut followed in 1921; and Indiana in 1923.

The successive studies have indicated that state departments of education have become increasingly aware of the value of adjusting the requirements upward as occasion allows. They are aware that improved preparation of nurses results in improved nursing service.

Types of certificates issued. Fourteen states issue "temporary" or "provisional" certificates to nurses who meet part of the requirements and follow this by a "permanent" certificate when full requirements are completed.

Because of shortages of qualified nurses during and following World War II, several states have issued "emergency" certificates, good only for the current year, to a nurse meeting all the requirements except completion of the college work, on the statement of the school administrator that she is the best available candidate.

Title of certificates vary from state to state but in an individual state, the grade of certificate issued to a fully qualified nurse is usually that which is issued to the qualified staff member in the other fields of educational work. In those states where classroom

teachers are allowed to work indefinitely under a certificate which is based on four years of professional preparation beyond high school, the nurse may be allowed a comparable arrangement—three years for her basic nursing education plus a year of college work. If five years is the usual requirement, the nurse's permanent certificate may require two years of college work in addition to the school of nursing.

Certification and salary schedules. A certificated school nurse, employed by a board of education, is usually placed upon the teachers' salary schedule at that point indicated by her preparation, pertinent experience, and the evidence of success in her work. Recognition for work beyond that required for her certification is given in accordance with policies applied in regard to other certificated employees.

Types of experience recognized in placement on schedule. In addition to previous experience in school nursing, recognition is usually given to experience in other types of public health nursing and for teaching. Some nurses were public school teachers before they entered nursing; others have had teaching experience in schools of nursing.

The application of new requirements to nurses employed previously. When higher qualifications are instituted in a school system than have previously been required, the new ones are not made retroactive. Nurses already employed are given the privilege of remaining in the service and keeping their places on the salary schedule at the point where their preparation and experience places them. They are given the opportunity to qualify for the new certificate if they desire, and in that case progress to a comparably higher place on the schedule. For the purpose of this additional preparation, leaves of absence should be arranged for those nurses desiring them. In some instances the board has arranged stipends as well as to assist nurses who wish to meet the new requirements.

Local standards. With the degree of local control of education practiced in the United States there are few school systems which do not exceed minimums established by the state in some area or other. There is variation in the amount of financial support avail-

able as well as in public demand for higher standards. Schools which set standards for teacher preparation higher than that of the state can logically do likewise regarding their nurses. In those situations, however, where the requirement that teachers have a master's degree is automatically extended to the school nurses, an injustice is done as these nurses may have obtained their nursing education in a school of nursing which is not incorporated in a university course. The requirement should be interpreted in terms of the number of years the nurse has gone beyond high school.

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Administration, Direction, and Supervision of School Nursing Service

Administration. There are a great many and widely differing plans for the administration of nursing services for school children. The most usual is that administered and financed by a board of education and utilizing specialized school nurses. Next in order of popularity are those administered jointly by school board and health department; a smaller proportion are administered by health department alone and still fewer by "other authorities" such as parent-teacher associations and county courts. In the last three types of administration either specialized school nurses may be used or the nursing service may be developed as part of a generalized public health nursing service.⁽¹⁾

Kilander's study ⁽²⁾ shows that of the 1566 cities with population of 2500 and over reporting health services in 1931, boards of education administered 60.2 per cent and financed 54.9 per cent.

Specialized school nursing service was reported by 54.1 per cent of the school systems; nursing services as part of a generalized public health nursing service were reported by 30.6 per cent.

Health departments were reported as administering 10.5 per cent and financing 10.5; health departments and boards of education jointly were reported as administering 23 per cent and financing 23.3 per cent; other authorities as administering 5.9 per cent and

financing 11.3 per cent. The assumption often made that administration by board of education implies specialized service and that involving the health department means use of a generalized plan is not borne out by these data; a total of 39.8 per cent of the school health services being reported as administered other than by boards of education alone. It is apparent that even if it is assumed that all the nursing administered by boards of education is specialized (though there are exceptions) there must be about a third of these other administered services which use specialized school nurses.

As a professional employee in a school health service, however administered, the nurse ordinarily has little part in determining the type of administration under which she works. Administration of schools is a citizen responsibility, carried by citizens as they function through state or local governments. In some instances, the method of administering school health services is established by citizens through action of their state legislatures; in other states the method to be used is considered to be a matter to be determined by local boards of education. As a citizen, the nurse may participate in the establishment of such procedures whenever the opportunity is offered. When a change of administrative plan is under consideration, the nurse as a professional worker may assist in research to gather pertinent information from professional sources, or to collect and analyze local data bearing on the results of the present administrative system, for presentation to what ever body is to make the decision.

The nurse's usual role is to work as effectively as she can under the established administrative system.

Rogers ⁽³⁾ in discussing state-wide trends in school hygiene, as indicated by laws, regulations, and courses of study says of state legislation in regard to health services for school children:

In 30 states the law is more or less mandatory. The State board of education is responsible for carrying out the law in 11 states, the State department of health is responsible in seven; and joint action is advised in 11. However, the "responsibility" especially of departments of health seldom includes more than the prescribing of examination forms. In joint supervision this is usually the function expected of the health

department. The local responsibility rests in 33 states with the board of education and in four with the board of health. In two it is placed jointly.

The following tables ⁽²⁾ show the shifts in administrative control since 1922:

TRENDS IN THE ADMINISTRATION OF SCHOOL HEALTH SERVICES
IN CITIES OF 100,000 OR MORE POPULATION: 1922-1950

Responsible Authority	Year			
	1922	1930	1940	1950
1	2	3	4	5
	%	%	%	%
Board of education	51	60	65	61
Board of health	27	26	31	13
Joint	22	14	4	23
Other	0	0	0	3
Total per cent	100	100	100	100

TRENDS IN ADMINISTRATION OF SCHOOL HEALTH SERVICES IN
CITIES FROM 30,000 TO 100,000 POPULATION: 1922-1950

Responsible Authority	Year			
	1922	1930	1940	1950
1	2	3	4	5
	%	%	%	%
Board of education	77	78	71	66
Board of health	10	14	23	14
Joint	10	5	6	19
Other	0	0	0	1
Private	2	0	0	0
Health and other	0	1	0	0
Education, health and other	0	2	0	0
Not stated	1	0	0	0
Total per cent	100	100	100	100

Direction and supervision. Fundamental principles and techniques of direction and supervision apply and are needed in the

public health nurse's work in the school as in other areas. With such principles and techniques, most administrators, directors, and supervisors are already familiar. The purpose here is to apply them to the problems of nursing in the school health program.

The school administrator will be shown the benefits of direction and supervision by nurses for the nurses working in his schools. When the work done by nurses under nurse direction is compared with that accomplished by nurses working in a comparable situation but lacking such assistance, its values become quite apparent.

The nurse preparing for school work and the nurse now so engaged but working without nurse direction will acquire greater understanding of the benefits which such leadership offers to the program and to them, personally. In some instances they will gain a changed conception of these functions.

In practice the line of demarcation between the work of a director and supervisor is often not wholly clear either in the school world or in the world of public health. Invariably there seems to be an overlapping between the functions of the two. A responsibility which may be assigned to a director in one situation may be given to a supervisor in another.

Director of school health service and nursing director. Great diversity of practice exists in regard to the assignment of function to these two officials. The line of authority however is clear. The director of nursing works under the director of school health service. In instances where the director of health service is employed by the school and nursing service is supplied by another agency, the director of nursing service is assigned part time to the school service, which may or may not then pay part or all of her salary.

Medical direction. Any nurse working in a school whether employed by school authorities or by another organization works under direction of the superintendent of schools as a matter of course, just as does every other person working in the school. Because of the nature of nursing service, however, she is also under the professional direction of a physician who himself works in the school under direction of the superintendent. This is equally true of the physician assigned to school duties by the health depart-

ment, or the one who volunteers his services, or the physician employed by the board of education.

Direction of nursing service in a school derives then from a minimum of two sources and sometimes from three or four. Between the superintendent and the nursing service there may be a director of health service, a director of medical service, and a director of nursing service. In contrast, supervision of school nursing comes only from one source—a nursing supervisor. By its very nature supervision of a nurse can come only from another nurse.

Delegation of directional authority to one director. Although top direction as described above may stem from several sources, it is essential that there be one director of nursing service and no more. The situation of the nurse is unusually complicated at best and to complicate it further with the disorders of a conflicting or overlapping direction may be disastrous. If confusion and inefficiency are to be avoided, superintendent, principal, director of health services, medical director, and nursing director must together agree upon policies.⁽⁴⁾ Then authority to carry out these policies must be vested in one individual. It is true that such an individual will usually be one of those mentioned. Also he may need to use care to keep his policy-making role differentiated from his administrative one.

Director of health service. Nurses with exceptional preparation, experience, and personalities have served excellently as director. It is more usual, except in the largest of school systems, to find a physician directing the nursing work along with the medical program and perhaps the dental program. He may also direct any or all of the following services—mental hygiene, psychiatric and psychological services, attendance and guidance, special education and services for the handicapped, nutrition program, and the educational programs of health, safety, and physical education.

In some large systems an assistant superintendent of schools has directive responsibility for all health services.

Coordination of services by the director. An important part of the director's responsibility for the nursing work is coordination of the policies and procedures of nursing activities with those of

the various other pupil personnel services of the school and community. First, coordination includes within the school a careful intermeshing with the activities of the medical and dental programs. A relationship almost as close must be established between the nursing program and the programs of attendance and guidance, with the psychiatric and psychological services, and with the special educational facilities and services for the handicapped.

Coordination with classroom health teaching. The director must give special attention to plans designed to integrate the health teaching of individual pupils, parents, and teachers, done by the nurses, with that carried on in the classrooms in the programs of health, safety, physical education, nutrition, home economics, science, and social science. This involves, in addition to mutual participation in curriculum construction projects, a continuous process of staff education.

Coordination of nursing with out-of-school activities. Careful planning with child service agencies in the community is necessary to avoid overlapping and omissions and to reduce confusion by an effective allocation of respective responsibilities. Also specific effort is required to eliminate both apparent and actual contradictions in teachings and in procedures. Program and methods of the school nursing service must be synchronized with those of health and welfare agencies, public and voluntary, dealing with children of school age. Even when the nursing service is administered by the health department, harmonizing the activities of the school nursing service with those of other health department services is required. Being in the same department does not ensure that the desired harmony will occur spontaneously.

The director arranges with the youth character-building agencies such working relationships as will allow each to utilize for the profit of the child as much of the work of the other agency as possible.

Coordination with the organizations carrying on adult education is often overlooked, but offers valuable possibilities.

Director's function in general administration. Participation in the development of *all* school policies is another important

function of the director. This is necessary to ensure consideration of such health principles as are applicable to the particular matter under consideration. Few situations do not have some health implications, potential if not present.

Direction of a nursing program includes, of course, the usual directional responsibilities, such as preparing a budget, establishing salary schedules and other personnel policies, arranging working facilities, obtaining equipment and supplies, and directing the work of supervisors and staff.

Qualifications of the director. In addition to the many general qualifications required for a director of any service in a school system or a health department, the director of school nursing service needs to have had intimate experience with the work nurses do with school children in their homes, in classrooms, and in the community. He needs firsthand knowledge of the possibilities of their relationships to other school and community services for children. It is observed that a director employed by a school system is more apt to lack understanding of such possibilities in relation to nurses of other nursing agencies; the official employed by a health department to direct the school nursing service may have an equally serious handicap in failure to recognize important potentialities in relation of the nurses to other school personnel.

Supervision. A nursing supervisor in a situation where there is no nursing director may carry any or all of the functions described as relegated to a director. In a system without a full-time medical director, or even in a very large school system with one, she is frequently assigned many of the functions really belonging to a medical director. Under the title of "supervisor" she may be acting as an "assistant director," perhaps of other services as well as of her own. Such a supervisor, if she has sufficient administrative ability, may successfully assist in the direction of such programs as dental hygiene, safety, psychological service, and nutrition. She must, however, carefully refrain from attempting to "supervise" dental hygienists, psychologists, nutritionists, or dietitians; for just as only a nurse can supervise nurses, a nurse can supervise only nurses.

In a system with from two to six nurses the supervisor often carries a part-time field assignment, or a teaching schedule, in addition to her supervisory activities.

In a large school system, if there is provision for adequate general, medical, and nursing direction, and if the nurses are well prepared for school work, a ratio of 1 supervisor to 12 or 15 nurses may prove adequate. In agencies having 7 to 14 nurses, a full-time supervisor is often found, though an analysis of the activities of such a "supervisor" often reveals she is carrying many duties of a director.⁽⁵⁾

Of course when a staff includes a considerable number of nurses who are inadequately prepared for nursing in a school health program, more supervisory time is needed. In-service teaching requires much more time. "Training on the job" has definite advantages in school work but only provided the nurses have good educational and professional backgrounds and have been carefully selected because of their personal fitness for work with school age children, parents, teachers, and community agencies. It is a waste of time, energy, and money to try to make up for fundamental lacks in educational and professional preparation or in personal attributes, by intensive supervision and an exaggerated in-service education program.

Lack of school nursing supervision. Less provision for supervision is made by boards of education for nurses employed by them than is supplied for public health nurses employed by other agencies. In "Report Prepared for the Committee to Set Up Standards of Supervision for School Nursing"⁽⁶⁾ the statement is made: "If all the public health nursing supervisors now employed by departments of education, health departments, and other health agencies were pooled, enough supervisors would be available to bring the ratio up to 1 supervisor to 9 nurses. But the ratio of nurses to supervisors employed by public schools is 1 supervisor to 49 nurses."

The 1952 public health nursing census made by the United States Public Health Service showed that boards of education employed supervisors at a ratio of 1 supervisor to 41 nurses; local health departments, at a ratio of 1 to 9 public health nurses.

State school nursing supervisors. The statement of the responsibilities of a state supervisor of school nursing may sound quite similar to that describing those of a local supervisor, but the emphasis is apt to be different—much more on activities of a consultative and directional nature than on the truly supervisory.

More of her time must be used for working with school administrators, individually and in groups. There are several reasons for this. She is involved with a greater number of them than is the usual local supervisor. Her relationship with them is more difficult; because the administrator has selected his local supervisor and she is on his payroll, he considers her "his own." The state supervisor is a person whom he had no personal part in selecting; he recognizes she has many other loyalties in addition to or perhaps competing with a loyalty to him; he may subconsciously or even actually feel her to be his rival in authority over his nurse or in the direction of the health service program. A similar situation may exist in the case of a county supervisor.

Such a supervisor therefore must use considerable effort to offset such feelings on the administrator's part; to convince him that her objective is the same as his in reference to his nursing service, the best nursing service that can be attained; to demonstrate that she has no ambition to rival his authority or his status in the school; and to develop his personal confidence in her as a person and in her ability so he will freely seek her help.

In current state supervising positions the ratio of nurses to supervisor is so large that the assistance given to the majority of the nurses in her jurisdiction is limited to that obtained through meetings, periodic "newsletters," and individual correspondence, with only a limited number of supervisory visits. Through the first two means the supervisor keeps the nurses informed of new laws and regulations concerning health, education, and social welfare for children, of helpful publications in the fields of the nurses' interests, of educational opportunities, and of prospective meetings of value for them to attend.

Through correspondence she gives some assistance on individual problems, and through letters from administrators as well as from

the nurses she learns of those situations where her field visits are most needed.

By representing the nursing point of view when state regulations are being set up or when state health and educational publications are being prepared, she makes a contribution to the children in the state as well as to the nurses working in the program.

In a state supervisory position or in a large or densely populated county, the supervisor may find it a problem to keep a register of the nurses under her up to date. Especially is this apt to be true in the fall as school opens. A formal request, sent out as school opens, to each school administrator asking for the names of any new nurses and for the current addresses of all of his nurses is the first step. Cooperation with local nurses' groups such as those described in Chapter 22 is a valuable supplement; the supervisor sends the secretary of each group the names of new nurses in that particular area, and the secretary sends her whatever information she has obtained from her group.

Periodically to all nurses and immediately to new nurses the supervisor sends a request for information regarding the nurse's assignment, her professional and general education, nurse's registration, and in localities where certification is required a statement of the certification held. As soon as the nurses are convinced that the information they furnish will be used only to the advantage of themselves and their programs and never "against" them, they are ready to give in addition to these items more personal information, such as date of birth, a listing of all professional experiences with dates, salary, classification on the salary schedule, reimbursement for transportation, the number of scheduled hours worked, and an estimate of the unscheduled time used.

Anticipation that she will be able to compare such details of her own situation with those of others is attractive to the nurse. The value of some of the data in planning educational opportunities for a group of nurses in a geographical area is self-evident. The nurses come to understand that the supervisor will be able to give more specific help to a nurse who writes her concerning various problems if she possesses such background material.

A nurse may ask the supervisor for the names of other nurses who are interested in some problem she is concerned with, so she may discuss possible solutions with them or perhaps use a "visiting day" to visit a nurse in a situation similar to her own. Committees to do group work on selected problems may be more intelligently chosen, with such information on file.

New Jersey State Association of School Nurse Supervisors. This association believed to be the only one of its kind in the country was organized in 1950. One-day meetings are held twice a year, in the fall and spring. Each meeting is held in a different place giving the members an opportunity to observe various types of health facilities and programs. Local administrators are brought into the discussions; special studies are presented by members or invited speakers. Committees work on selected problems, one of which has been the determination of desirable qualifications for school nursing supervisors.

Value of supervision. Considered in its present concept, supervision is as valuable for the nurse working in a school situation as for the nurse working in any public health situation. This concept is that of a cooperative working together of a nurse and supervisor to analyze the problems of child, teacher, or parent and to coordinate the nurse's efforts with those of other community workers concerned with the problem. The field in which the school nurse works has become so broad; psychological, scientific, and educational advances occur so rapidly; that no one nurse through her own efforts alone can keep pace with all the new material developed. In this also she needs the help of her supervisor.

In an earlier day when there was more emphasis on the inspectional role of the supervisor, and the administrative functions assigned to her often crowded out educational and advisory help to the staff, perhaps there was less need in the school for the same intensity of service from a nursing supervisor than needed in other public health situations. Then the nurse in the school was already under the direction of the school administrator. Often to a greater degree than other public health nurses, she was receiving medical direction for the school work. Also by the very nature of school

service she required less "checking up" to ensure that her time was spent on the job. Another factor which is still operative was the lesser turnover among nurses employed by boards of education than in other nursing services.

To a lay person the need for nursing supervision for a nurse who uses comparatively few nursing procedures may seem less obvious than when her work includes more "real nursing"—more of the procedures associated in the mind of the public with bedside care. Actually her need for supervisory help is greater when her work demands skilled health counseling, teaching ability, and leadership, in all of which she has had less preparation than in nursing procedures. Also, she may find the schools and the parents much more sophisticated in "health" matters than they are in nursing procedures and possibly more critical in these more familiar areas.

One of the supervisor's greatest services to a nurse working in a school is the help she gives the nurse in developing her own capacities. One of her services most appreciated by the school administrator is the leadership she gives to the nurses as a group, unifying and coordinating their individual efforts, thus raising the level of the nursing service as a whole.

Some of the most easily recognized advantages of supervision are demonstrated when a new nurse is added to the staff. The assistance given her saves her embarrassment but does much more, for it may mean the difference between success and failure. The school system saves a definite amount of time which might otherwise be lost while the nurse fumbles around trying to work things out for herself. More serious are the confusions which may occur or actual damage that may be done to parent or community relationships through her ignorance of policies and procedures that parents and other workers have come to understand and expect.

Supervision increases the effectiveness of temporary nurses who must be added in time of emergency. Substitute service is difficult without supervision. Even when a school is fortunate enough to have an adequate list of qualified experienced nurses on whom it may call, their work is more immediately effective if a supervisor's help is at hand.

As a result of supervisory activities, the professional interest of the nurses in their work is frequently intensified. The best ideas of each nurse receive more recognition; the group is stimulated to try out new methods. Creativeness is also given impetus because the supervisor is always accessible to discuss new theories and to offer special understanding and interest. On the other hand, in regard to certain procedures, parents, teachers, and workers of community organizations find it more satisfactory when there is a uniformity of action, in contrast to the situation that exists when each nurse on the staff "has her own way of doing things." It is important to utilize to the maximum the creative ability of all nurses; it is equally important to avoid confusion and loss of time by the establishment of definite routines which will accomplish desired results more quickly, smoothly, and effectively.

It is possible to arrange a more equitable sharing of work when there is a supervisor to see the situation as a whole, both as the year's program is planned and assignments are adjusted as emergencies come up. Whenever two or more nurses are working together, there is less time wasted fumbling with the mechanics of operation, if procedures have been worked out previously on an impersonal basis under a supervisor's leadership.

The supervisor may furnish a creative or a frustrating leadership to the nurses she supervises. While the director of a service may desire a democratic staff participation in planning and executing the work it is the attitude of the supervisor which determines whether or not there is satisfactory joint action. Her part in developing personnel policies, and the direct responsibility usually assigned to her to administer them, may place on her shoulders establishment of the emotional climate in which the staff works and lives.

To their supervisor the nurses look for interpretation of new education or health department policies. They expect her to give them opportunity to become informed concerning new scientific discoveries, new educational theories, and any new developments in local programs. They rely upon her to see that they become skilled in any new procedures assigned to them.

Under the direction of her superior, whether director or administrator, the supervisor plans work assignments for the staff and assists nurses in making their individual work schedules. She gains sufficient familiarity with the abilities, activities, and accomplishments of each nurse so she can assure herself that the work is being properly done and that it will be completed in the available time. Periodic review of each nurse's activities by nurse and supervisor is necessary to keep down the non-nursing duties which are so apt to accumulate in the nurse's work. She helps protect the nurse from becoming isolated in everyday "routines."

Under direction of her administrator, the supervisor recruits applicants and helps select nurses to fill vacancies.

The supervisor's role (and that of her administrator also) as a channel through which staff members make contact with workers of cooperating staffs in school, health department, and other community agencies is perhaps less in the school situation than it is in some other types of nursing services. Here, however, the supervisor has an important part to play in encouraging direct contacts by the nurses with other staff workers, face to face, or by telephone or letter. She assists in setting up devices to facilitate her nurses coming together with other workers. She works with supervisors and directors of cooperating agencies to plan staff education activities that will help her nurses and cooperating workers to recognize occasions when conferences are indicated. This means she works on such committees as those of principals, of attendance and guidance workers in the school, and of representatives of nursing, health, and welfare organizations outside of the school, to analyze problems of communication and develop policies. Guides are drawn up to help staff members of all agencies become sensitive to opportunities to work more closely together for the benefit of the child.

When it is merely a matter of exchange of information between two workers it is simple to "send it through" in the safest, quickest way. But when the needs of the child are such that he requires the services of more than one agency, the process necessary is apt to be more than a mere exchange of factual data. Actual working

together in an attempt to find a solution of the problem may be indicated.

After a new nurse is oriented in her situation, the school nursing supervisor accompanies the nurse as she works less often than do nursing supervisors in some other areas of public health nursing. Since the work is largely a matter of human relationships, one cannot "show another how to do it." One can only give her some help in her own learning how. Availability to talk over difficult situations, to plan tentatively certain possible approaches, and later an opportunity to describe to the supervisor what took place, to analyze with her possible causes and effects, and discuss possible next steps, seems to be the type of supervisory help most valued by a nurse. This assumes a nurse with a good educational background and proper professional preparation who is well oriented in the school setting and well grounded in the technical skills involved in such activities as testing, interviewing, recording, or the like.

While one of the acknowledged purposes of supervision is to stimulate group thinking and group action and to secure a certain desirable degree of uniformity in procedures and programs, the emphasis is on helping each individual develop her unique contribution rather than on forcing all into a common pattern. The supervisor is an analyst not an inspector; a mediator not a dictator; a leader not a driver. Instead of exercising the authority of an overseer, originally inherent in the position, she tries to help her staff members not only to see their own jobs but to look over and beyond to the work of the organization as a whole.

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Selecting the Nurse's Activities

No complete agreement exists among authorities on school health service—school administrators, public health and public health nursing leaders—as to just what activities a nurse's services in a school should include. In certain well-defined areas, however, the special value of her services is widely recognized.

Pupil loads. Pupil loads vary, when the nurse is employed by a board of education, from two or three hundred to five thousand. In generalized public health nursing programs, the variations may be even greater as she may be responsible for serving a population of from three thousand to thirty thousand people including the schools and with or without bedside service. With a small population, if bedside service is not included, the generalized public health nurse may give more time to the school service than is given proportionally by full-time school nurses. Usually, however, the amount of service tends to be greater when furnished by the school itself than when it is part of the service of another agency.

There are many reasons for the lack of studies to establish the amount of time needed for the nurse to meet the nursing needs of school children. The most obvious is the variation in what are considered nursing responsibilities in school health services. There is lacking, also, complete information about the actual ratios of nursing time to pupil loads, especially in generalized services.

In some states, where the program is fairly definite in stating

nursing responsibilities, state agencies have made more or less definite recommendations for desirable ratios of nurses to pupils.

1. A recommendation established as a result of a three-year study by a State Survey Committee appointed by the New York Department of Education, which reported in 1947, sets up for urban areas 1 nurse for 1000, and for rural areas 1 nurse for 500. Actual ratios (exclusive of New York City, Rochester, and Buffalo whose school nursing service is by health departments and from whom no data are available) are for 1050 nurses. In urban areas these are: 1 nurse for 1132 when a nurse serves only pupils in public schools, and one for 1340 when she serves pupils in public and parochial schools. In rural areas the ratio is 1 nurse to 874 pupils in public schools only, and 1 nurse to 914 pupils when she covers both public and parochial schools.

2. The Illinois Department of Public Instruction recommends 1 nurse to 1500-2500 pupils. A study recently made on 205 nurses doing full-time school nursing, out of a total of 261 such nurses, shows an average load between 1400 and 1500.

3. The New Jersey Division of Education recommends 750-1500. A study has shown the actual ratio to be approximately 1500 on the average.

4. The New Hampshire Department of Education recommends 500-800 for rural areas, and 1500 for urban areas.

5. The New Mexico Department of Education for an urban area with specialized school nurses recommends 1500-3000.

6. In Pennsylvania, the ratio is 1 to 1500.

7. In Minnesota the ratio of nurses is higher in Minneapolis—1 to 800—than for nurses employed by other boards of education in the state for whom the average is 1 nurse to about 2000 pupils.

Other ratios are significant. In generalized public health nursing service which includes school work where the usual recommendation is 1 nurse to 5000 population, there is often an assumption that one fifth of the nurses' time will be spent on the one fifth of the population which makes up the school enrollment. This indicates roughly one day a week for a thousand pupils which would be

proportionate to a full-time nurse for 5000 pupils when the nurse serves only school children.

Actually, however, the proportion of time is usually much greater or much less, depending on the philosophy of the director of the service. Since the school organization offers one of the most effective opportunities to "spread" services given, and to reach a greater number of families than can be reached by the nurse working in other programs, a greater proportion of time may be allowed for school activities; on the other hand, since the school age group is made up of the "healthiest" members of the population they may be considered to merit less than their proportionate share of the nurses' time.

Various state health departments describe the amount of time spent by generalized nurses on school work as "20-30 per cent of their time," "16.5 per cent of their time," "more than half of their time," "very little time," "as much as possible," "they give more time to the school service than to other services," and "from 1 to 1½ days per week in the schools."

Responsibility for planning the nurse's program. Under any type of administration, planning of the nurse's program is a mutual problem of school administrator, nurse, and physician.⁽¹⁾ In a service supplied by the board of education, the physician is usually employed by the board; under the health department, a physician employed by that department. In either instance if no physician is employed, a representative of the local medical group may be asked to assist with the planning. The physician is needed in sound planning. First, his point of view differs from that of a school administrator or a nurse; second, his active interest at the planning stage helps secure his and other physicians' participation, support, and understanding which are involved in every phase of the nurse's work with school age children. Her work is based on that of the physician, as he functions as family physician, health officer, or school physician.

When the nurse is employed by an agency other than the school, this planning must be preceded by a definite understanding between her employing agency and the school, both as to the amount of time

she will give to school services and as to the activities and responsibilities she will assume.

Planning assignments for a staff of nurses. After the group described above has planned in a general way the nursing program for the following year, specific assignments for the various nurses are usually the work of the nursing director or supervisor.

For a staff of nurses or a single nurse employed by the board of education, the fall schedule is usually worked out in the preceding spring. The generalized nurse working alone is more apt to do her planning in the fall especially if working in a rural area. Then if possible she arranges with the school administrator to confer with her and his teachers at their preopening-of-school meeting. (See Chapter 19.)

Division of work among several nurses. When work is to be divided among two or more nurses, it can seldom be divided satisfactorily on a numerical basis alone, either by numbers of pupils or numbers of schools. One reason is that in no two schools, even in the same school district, with the same nurse and with perhaps the same nursing program on paper, does it work out that the nurse has identical activities. Needs of the pupils vary; what parents and teachers assume of the responsibility varies, the school buildings and settings are different.

Among the factors which influence the number of pupils to whom the nurse can give adequate service in a given amount of time are:

1. Interest and participation in the health program on the part of principal and teachers. Personal variations occur among the teachers, and emphasis given health by the principal causes even greater fluctuations between schools.
2. Effectiveness of cooperation with other school officials in carrying out health service procedures. Individuals and cooperating staffs vary, just as do nurses, in their abilities and enthusiasms.
3. Accessibility of community health and welfare agencies and the effectiveness of coordination of the nurse's work with the work of these agencies—public health nurses employed by agencies other than the one employing the nurses working in the schools, hospital outpatient departments, Red Cross, social services, mental hygiene

and child guidance services, and others. Variations in the personnel assigned to the areas of the different schools, location of substations and regional offices, transportation facilities—all influence the accessibility of cooperating services.

4. Amount and effectiveness of parental education in the area; readiness and ability of the parents to come to the school for conferences; economic and living standards of families from which pupils come—all of these relate to the amount of time needed properly to serve the pupils' needs.

5. The adequacy of public transportation facilities enters in if the nurse does not have the use of a car.

6. Number of schools in which the pupils are distributed; the type of schools—urban, suburban, rural, or elementary, secondary, vocational; distance between school buildings; geographic aspects of the area; location of the homes of the pupils—dense population or scattered.

7. Extent of specialized health services provided by the school system.

8. Amount of clerical service provided.

9. Adequacy of telephone service in the school and in the homes.

Careful and long-term planning of assignments of nurses to the schools within a school system should make changing a nurse from one school to another a rare necessity. Stability of the nursing service is especially important in school service. "Learning" a school takes time and effort. In a school which a nurse "knows," the same time and effort can be devoted to getting results. It is true the nurse who is unacquainted with a child can do as good a job technically of first aid. The concomitant teaching, especially as it relates to establishment of attitudes, toward himself, toward his health, toward enduring pain, may be much more effective when the nurse knows him, his history, and his family. The actual teaching needed in one instance may be quite different from that which is needed in another. If he comes from a family accustomed to ignore first-aid procedures, a different emphasis is needed than if his mother is inclined to baby him on any provocation.

"Knowing" a school goes deeper than a mere familiarity with the names of the teachers, the home addresses of pupils, and the physical layout of the school buildings. It means being able to discount David's difficulty with the sixth grade teacher because of what the nurse learned of him last year in his relationship with the fifth grade teacher, or even what she learned of the sixth grade teacher year before last. She can save time in dealing with parents because she knows what the parents already know about children through her experience with them as they dealt with their older children or with this child in previous years. She can pick up the situation with them several steps further along the line than could a new nurse. The time saved is important. Probably more valuable is the greater success with the parent and child both in the results obtained and in the parent's satisfaction in being dealt with on the right level.

If the size of the pupil loads is not impractically large, there are many advantages in assigning to a nurse both the junior high school and the elementary schools which feed into it. This enables one nurse to follow the child from kindergarten through the ninth grade. It also means, with the exception of their high school children, the family will be dealing with only one nurse. A senior high school nurse may have less time available for home visiting (less need for it, of course). Assignments can also be arranged so that the nurse serving the elementary school in the district in which the family of a senior high school pupil resides will be available to make home contacts for the high school nurse, whenever the latter feels this can be done satisfactorily. (See Chapter 18.)

In a growing school system, new nurse positions are added; assignments are changed; in all schools experienced nurses resign; or illnesses require temporary readjustments. Several factors are taken into consideration in deciding placement of nurses in the schools:

What are the special strengths most needed by the nurse to be successful in the particular situation? Will she need to understand little children or adolescents? Foreign-born parents? Parents of high economic levels? Parents of high cultural levels? Or is the most

important need that for a nurse who can get the best use out of cooperating agencies? Or must first consideration be given to choosing a nurse who will know how to "get along with" a certain principal, physician, or guidance person? Or must the choice be limited to those nurses who have the physical stamina to climb the innumerable flights of stairs involved in a tenement area?

Certainly a nurse should not be changed casually from one school to another because of anyone's whim (even her own), or because of a personal preference of two individuals wishing to work together, or on the other hand because of a personal dislike of one person for another.

Even cutting down a few minutes of travel time a day should not be considered important enough to discard lightly the knowledge and understanding a nurse may have accumulated in even one year in a school. There is too much at stake.

Deciding the nurse's activities in a particular school. Within the amount of time available she is assigned first to those things which she can do better than anyone else, more effectively, or more safely. Then are added those things which she can do more economically than the others to whom the responsibility might be assigned. Whatever plans are made they must be flexible enough to allow her to meet the many emergencies which are an important feature of her work.⁽²⁾

Consideration of the nurse's school work as part of the school health program and of the school health program as part of the community health program. A practical method to ensure this point of view is to have plans for the nursing program incorporated in a general manual on school health services rather than as a separate manual on school nursing alone, and to have such a manual developed by a committee with broad representation. This type of manual has been found more useful to the nurse than one limited to nursing procedures alone. In many instances the nurse is the key person in getting things done for the pupil and she needs to have at her finger tips information about how the child's needs are to be met although at the moment it is not she who is to render the service.

addition, such services as communicable disease control, rehabilitation, and public health education are represented.

Either as members of the committee or some of its subcommittees are needed representatives of public and private welfare agencies concerned with the school age child and his family.

Representatives of any private or parochial schools which are to share the service are also included.

The committee to develop the manual is bound to be large even in a small community. A well-integrated nursing service for school age children, regardless of what agency carries direct responsibility for the service, naturally involves many educational, health, and welfare authorities and agencies. Assignment of specific items of work to properly chosen subcommittees is required.

"PREFACE" OR "INTRODUCTION" OF MANUAL. This is usually prepared by the committee but signed by the superintendent of schools since he represents the board of education which is ultimately accountable for the safety, health, and welfare of the pupils, whether the service is furnished by the school or by another agency.

SAFE AND HEALTHFUL SCHOOL ENVIRONMENT. In this section specific responsibilities are stated of the various individuals concerned—principal, custodian, teacher, physician, nurse, and others.⁽³⁾ The frequency with which formal inspections of premises shall be made, and the persons assigned to this duty are specified.

Methods are outlined for reporting any hazards to health, safety, or comfort which are discovered. If blanks are available for the purpose they are identified and the place to obtain them pointed out.

The amount of assistance the nurse can give in these activities is related to the amount of nursing time available for service to the school age child. The important consideration always to be kept in mind is, within the total time limitation, whether this or some other activity is more important for the nurse.

When nursing time is limited her assistance in planning may be more valuable than her personal service. The following list of possible activities is checked for three classifications of "Amounts of Nursing Service"—minimum, moderate, and liberal amount. Yes

in a column indicates that the activity may be expected of a nurse when the amount of time is that indicated at the top of the column. No indicates the activity should not be expected. It will be noted that with a minimum amount of time emphasis is upon use of the nurse's experience and judgment for planning rather than for service.

ASSIGNMENT OF DUTIES TO THE NURSE IN RELATION TO CONTROL OF ENVIRONMENT

ACTIVITY	When the Amount of Nursing Service Is		
	Minimum	Moderate	Liberal
1. Daily inspection of drinking fountain, toilet and wash rooms, first-aid stations	No	Assists	Yes
2. Periodic check of and report on hygienic practices in the school	Occasionally	Yes	Yes
3. Participation with administrator, physician, etc., (see page 308) in annual check of entire buildings and grounds	Yes	Yes	Yes
4. Follow-up of conditions needing improvement as assigned by administrator	Yes	Yes	Yes

CARE OF EMERGENCIES. The actual "instructions for care of emergencies" are often not included in the manual as they are subject to more frequent change than the manual may be. (See Chapter 13.)

Responsibility is assigned for seeing that current copies of these instructions are posted in the various buildings wherever first-aid supplies are located. The assignment may or may not be to the same individual to whom is assigned inventory and keeping up to standard of the first-aid supplies at the various stations.

HEALTH EXAMINATIONS AND TESTING PROGRAMS. Policies for scheduling physician's and technician's time for the various schools are stated. Instructions to the teachers regarding their selection of pupils for routine or special examinations are in specific detail.

ASSIGNMENT OF DUTIES TO THE NURSE IN RELATION TO CARE OF EMERGENCIES *

ACTIVITY	When the Amount of Nursing Service Is		
	Minimum	Moderate	Liberal
1. Preparing instructions for care of emergencies	Assists	Assists	Assists
2. Posting instructions	No	No	Yes
3. Explaining instructions to staff, pupils, and parents	Yes	Yes	Yes
4. Demonstrating proper procedures to use	Yes	Yes	Yes
5. Administering first aid	Assists	Assists	Assists
6. Making inventories and ordering first-aid supplies	No	Assists	Yes
7. Locating first-aid stations	Yes	Yes	Yes
8. Checking first-aid stations to see that supplies are adequate	No	No	Yes
9. Supervising stations to see that proper procedures are used	Yes	Yes	Yes
10. Reporting major accidents	Assists	Assists	Assists
11. Recording minor accidents	Assists	Assists	Assists
12. Reviewing and summarizing accident reports	Yes	Yes	Yes
13. Making recommendations directed toward avoiding accidents	Yes	Yes	Yes
14. Filing accident reports	No	No	Yes
15. Following up accidents	Yes	Yes	Yes
16. Supervising ill, injured, or isolated pupils at school	No	Assists	Assists
17. Contacting parents to have them send for ill or injured pupils	No	No	Yes
18. Taking ill or injured pupils home	No	Assists	Yes
19. Teaching first aid incidentally	Yes	Yes	Yes
20. Teaching Red Cross first-aid classes	No	No	Yes

* See page 129 for explanation of chart.

Responsibility for recording and reporting results of examinations and tests are definitely assigned.

Instructions for setting up the examining rooms and care of equipment are included.

See Chapters 8 and 9 for further suggestions of materials to be covered in this section.

ASSIGNMENT OF DUTIES TO THE NURSE IN RELATION TO EXAMINATIONS AND TESTS *

ACTIVITY	When the Amount of Nursing Service Is		
	Minimum	Moderate	Liberal
1. Checking pupil health records with classroom register	No	Yes	Yes
2. Making new health records for pupils not previously in school or whose cards are full	No	No	Yes
3. Obtaining health histories through questionnaires	No	No	Assists
4. Obtaining health histories through parent interviews	No	Yes	Yes
5. Recording attendance and scholastic standing on health record	No	No	Assists
6. Scheduling examinations	Assists	Assists	Assists
7. Preparing examining room	Plans	Plans	Plans
8. Preparing pupils psychologically	Plans	Assists	Assists
9. Preparing pupils physically	Plans	Plans	Plans
10. Being present at examination	Some	Yes	Yes
11. Annual weighing, measuring, and recording on health card	Plans	Assists	Assists
12. Periodic weighing, measuring, and informing parents of growth	Plans	Plans	Plans

* See page 129 for explanation of chart.

When the Amount of
Nursing Service Is

ACTIVITY	Minimum	Moderate	Liberal
13. Giving visual acuity tests	Assists	Assists	Yes
14. Giving color vision tests	Plans	Plans	Yes
15. Giving ocular muscle tests	Plans	Yes	Yes
16. Recording findings of vision tests on health records	Yes	Yes	Yes
17. Scheduling group audiometer tests	Assists	Assists	Assists
18. Giving group audiometer tests	Assists	Assists	Yes
19. Marking papers for audiometer tests	Assists	Assists	Assists
20. Recording hearing scores on health records	Plans	Plans	Plans
21. Scheduling true tone tests	Assists	Yes	Yes
22. Giving and recording true tone tests	No	No	Yes
23. Scheduling examinations of athletes	No	Yes	Yes
24. Assisting with examinations of athletes	No	No	Yes
25. Preparing history blanks for examinations for employment certificates	No	Yes	Yes
26. Being present at examination for employment certificates	No	No	Yes
27. Scheduling examination of school personnel	No	No	Yes
28. Being present at examination of school personnel	No	No	Yes

SECURING TREATMENT FOR PUPILS FOUND TO NEED IT IN DAILY HEALTH SUPERVISION, BY TESTING OR EXAMINATIONS. It can be anticipated that this will be one of the largest sections and most difficult to prepare in the manual. Differentiation of responsibilities and activities between health, welfare, and education authorities is not simple. Even within the health service staff interrelationships must be carefully studied and analyzed before procedures are worked out.

ASSIGNMENT OF DUTIES TO THE NURSE IN RELATION TO FOLLOW-THROUGH *

ACTIVITY	When the Amount of Nursing Service Is		
	<i>Minimum</i>	<i>Moderate</i>	<i>Liberal</i>
1. Writing notices of defects to parents	No	Assists	Assists
2. Addressing defect notices	No	No	No
3. Obtaining return of defect notices	No	Assists	Assists
4. Classifying returned defect notices and entering data on pupil's health record	Yes	Yes	Yes
5. Filing returned defect notices	No	No	No
6. Making arrangements for supervision of limited or rejected applicants for employment certificates	Yes	Yes	Yes
7. Preparing lists of defects for each teacher's work sheet	Assists	Assists	Assists
8. Interviewing teachers to discuss conditions with them	Yes	Yes	Yes
9. Interviewing pupils in school regarding treatment	Assists	Assists	Assists
10. Interviewing parents in school regarding treatment	Assists	Assists	Assists
11. Interviewing parents at home regarding treatment	Yes	Yes	Yes
12. Arranging for specialists' examinations to secure diagnoses, if necessary	Yes	Yes	Yes
13. Verifying and recording treatments	Assists	Assists	Assists
14. Securing modified program for special cases	Assists	Assists	Assists

* See page 129 for explanation of chart.

ASSIGNMENT OF DUTIES TO THE NURSE IN RELATION TO FOLLOW-THROUGH (Cont.)

ACTIVITY	When the Amount of Nursing Service Is		
	<i>Minimum</i>	<i>Moderate</i>	<i>Liberal</i>
15. Planning for educational adjustment for handicapped pupils	Assists	Assists	Assists
16. Making individual state department reports on handicapped pupils	Yes	Yes	Yes
17. Recording treatments on health record cards	Assists	Assists	Assists
18. Child guidance clinics—scheduling appointments	Yes	Yes	Yes
19. Child guidance clinics—obtaining histories	Yes	Yes	Yes
20. Child guidance clinics—attending	No	Yes	Yes
21. Child guidance clinics—following up recommendations	Yes	Yes	Yes
22. Tuberculosis clinics—scheduling appointments	Yes	Yes	Yes
23. Tuberculosis clinics—attending	No	Yes	Yes
24. Tuberculosis clinics—following up recommendations	Yes	Yes	Yes
25. Orthopedic clinics—scheduling appointments	Yes	Yes	Yes
26. Orthopedic clinics—attending	No	Yes	Yes
27. Orthopedic clinics—following up recommendations	Yes	Yes	Yes
28. Preparing form letters for parents regarding treatment	Yes	Yes	Yes
29. Preparing articles for public education regarding treatment	Yes	Yes	Yes
30. Preparing talks for public education regarding treatment	Yes	Yes	Yes

ASSIGNMENT OF DUTIES TO THE NURSE IN RELATION TO FOLLOW-THROUGH (Cont.)

ACTIVITY	When the Amount of Nursing Service Is		
	Minimum	Moderate	Liberal
31. Confering regarding treatment with public welfare officials	Yes	Yes	Yes
32. Confering regarding treatment with children's court judge and worker	Yes	Yes	Yes
33. Confering regarding treatment with health department officials	Yes	Yes	Yes
34. Confering regarding treatment with nonofficial agencies	Yes	Yes	Yes

DAY-BY-DAY HEALTH SUPERVISION OF PUPILS. Materials supplementary to this section may be issued in greater detail to teachers and parents, but all general policies regarding referrals for suspicion of communicable disease, referrals by the teachers to nurse or physician for special inspection, transporting of ill children, modification of school program, exclusions, readmissions after illness, and the like are formally stated here.

ASSIGNMENT OF DUTIES TO NURSE IN RELATION TO DAY-BY-DAY HEALTH SUPERVISION *

ACTIVITY	When the Amount of Nursing Service Is		
	Minimum	Moderate	Liberal
1. Inspecting and interviewing pupils returned from illness absences	Occasionally	Selected cases	All
2. Inspecting and interviewing pupils referred by teachers because of variations from normal	Occasionally	All	All

* See page 129 for explanation of chart.

**ASSIGNMENT OF DUTIES TO NURSE IN RELATION TO
DAY-BY-DAY HEALTH SUPERVISION (Cont.)**

ACTIVITY	When the Amount of Nursing Service Is		
	<i>Minimum</i>	<i>Moderate</i>	<i>Liberal</i>
3. Classroom inspections in epidemic situations	Some	Some	Some
4. Periodic classroom inspections for cleanliness and health habits of pupils	No	After vacations	After vacations
5. Group conferences with teachers to discuss their techniques of daily inspections of pupils and handling of problems found	Occasionally	Regularly	Regularly
6. Individual conferences with teachers regarding problems of daily health supervision of individual pupils	As needed	As needed	As needed
7. On excluded cases, giving information and instruction to parent by note, phone, or in person	In extreme cases	Assists	Assists
8. Reporting to health officer	No	Assists	Assists
9. Notification, when indicated, of groups of parents concerning prevalence and symptoms of certain disease to which their children may be possible contacts	Assists	Assists	Assists
10. Conference with parents in school or home re pupils' health or cleanliness habits	Yes	Yes	Yes
11. Investigation of pupils absent from school because of illness, type unknown	Yes	Yes	Yes
12. Annual weighing and measuring of pupils	No	Assists	Yes

**ASSIGNMENT OF DUTIES TO NURSE IN RELATION TO
DAY-BY-DAY HEALTH SUPERVISION (Cont.)**

ACTIVITY	When the Amount of Nursing Service Is		
	Minimum	Moderate	Liberal
13. Periodic weighing and measuring of pupils	No	No	Assists
14. Review of weight records and follow-up of indicated cases	Yes	Yes	Yes
15. Vision retests as indicated	Yes	Yes	Yes
16. Hearing retests as indicated	Yes	Yes	Yes
17. Inspection of new entrants when physician is not immediately available and no health records are transferred	Yes	Yes	Yes
18. Reinspection of pupils because of: suspicion of communicable disease, convalescence, return after accident, contact with tuberculosis, rheumatic fever, heart disease	Yes	Yes	Yes
19. Preparation of immunity lists	No	Assists	Yes
20. Cooperation with health department in developing immunization clinics	Yes	Yes	Yes
21. Recording causes of illness absences on health record cards	No	Assists	Assists
22. Recording of observations of school staff on health record cards	No	Assists	Assists

CHARTS. In a large school system or in a school health service where organizational relationships are quite involved, charts showing these are often included.

SAMPLE FORMS. Usually it is more economical and convenient for handling to have a separate reference book of forms and not to include them in the manual proper. Each however is carefully identified in its proper place in the manual.

SELECTED HOME VISITS TO BE MADE BY THE NURSE. General policies may be worked out to cover situations which may arise to help the nurse and administrator in planning home calls. No formula can be worked out that can be followed without frequent exceptions.

The following classification of home visits according to urgency, may be helpful in preparing a comparable classification for a particular school.⁽⁴⁾

<i>Situation</i>	<i>Call Urgent If</i>	<i>Less Urgent If</i>
1. Pupil sent home ill, injured, dirty, with skin or scalp infection or infestation	Family usually has no medical care, or parents need instruction, demonstration, or supplies for care (as in pediculosis)	Parent can be brought to school or usually secures medical care, or parent understands and follows written or phoned instructions
2. Pupil has acute behavior problems	When no one of school staff is as able as is nurse to obtain and interpret knowledge of family situations	Some other member of school staff with social work training can make the call
3. Visit requested for some special need	Requested by family, family physician, school physician, or school administrator	
4. Need for special information for child guidance clinic, or court orders for care and education for physically handicapped, etc.	Information is not already on file	Parent can be brought to school

<i>Situation</i>	<i>Call Urgent If</i>	<i>Less Urgent If</i>
5. Pupil is absent		
Following an accident	No known medical care	Family usually obtains medical care
Thought to be ill		
Suspicion of communicable disease	No known medical care	Family usually obtains medical care
No suspicion of communicable disease	No known medical care	Family usually obtains medical care
Suspected not to be ill	Persistent absence	
6. Follow-up needed to secure treatment of defects		
3x classification	No parent response after two weeks	Parent can be brought to school for conference
2x eyes and ears	No parent response after a second notice	Parent can be brought to school for conference
2x other defects	No parent response after a second notice	Parent can be brought to school for conference
(3x classification = severe defect, immediate follow-up 2x classification = defect which must be followed up but with less urgency)		
7. Follow-up needed to secure improvement in health habits, environment, or adjustments of program	Improvement is dependent on home conditions and parents' cooperation	Parent can be brought to school for conference, and home situation is already known

NOTE: It is impossible to compare the urgency of these seven groups except by the circumstances of the individual case. The great number of home calls, however, falls in groups 5 and 6. The subdivisions of these two groups are listed in order of urgency.

Judgment of the nurse. As much help as possible should be given the nurse in planning how her time should be spent by means of such procedures as are discussed in the preceding pages. What the nurse actually does at a particular time must rest upon the nurse's own judgment as there will be many instances which have been impossible to predict.

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Constructing the Nurse's Schedule

A tentative schedule for school visits is usually worked out by the nurse and her supervisor together, in accordance with the principles and procedures stated in her local manual. It is submitted to school administrator and physician for their suggestions and approval before it is posted.

If there is no supervisor, the administrator and physician may have a part in schedule construction.⁽¹⁾ However if they have already participated in the development of the manual, the nurse is often able to do her own scheduling.

Posting the schedule. Copies of the nurse's schedule are given to each principal and posted in the health office of each building so teachers may know when and where she can be located. A summons for the nurse which might otherwise be sent as an emergency may be postponed if it is known she will be there a little later without a special call. Pupils who might otherwise be sent directly home are more apt to be held for her to see. Both of these actions may mean better service for pupils and time saved for the nurse. Another saving of time and effort will result from planning before leaving each school what her work will be on her next visit there and leaving a note for the principal or any teachers involved.

Occasionally there will be emergencies which prevent the nurse from keeping these regular appointments. She notifies the school—if not beforehand, certainly by the time she is supposed to be there—

of necessary changes in plans and arranges to take care of any existing problems.

It is desirable to have a stated time when parents may expect to find the nurse in her office, except in emergencies. Office hours may be on a specified morning or afternoon and even in the evening (perhaps once a month) or on a Saturday morning, if such a time seems to fit in better with the needs of the community. Announcements are published in the school paper, the local paper, sent to parents in a form letter, or incorporated in defect notices. Some nurses find it convenient to have office hours stated on their calling cards, which they leave in the home as they make home calls. (See Chapter 10.)

Preliminary schedules. In the first week or two in the fall it is usually inadvisable for a new nurse to follow a rigid schedule. She visits her schools successively, as rapidly as possible, to assist teachers in determining disposition of any pupils with abnormal conditions found in the classroom teachers' first inspection. (Inspection occurs immediately after entrance of the children; it does not await the nurse's arrival.) Some of these pupils are referred to the family physician or school physician. Parents are informed of findings by note or telephone. Some conditions, however, require home calls, and by making these immediately, inconvenience and misunderstandings may be avoided. Respect of the parent for attendance laws may be greatly increased if he experiences this evidence of concern over possible loss of a day or even a half day of school, at the beginning of the term. Value and economy of early medical care is stressed, as well as the need to keep ill children from school.

In the case of a new nurse or a new assignment of work, this week or two of flexibility gives her an opportunity to try out distances, to become familiar with travel time involved, and to obtain an idea of the types of problems presented by the varied school population. She is then in a better position to allocate her time. It may be a serious mistake to divide her time on the basis of numbers of pupils alone.

Usually the nurse's program is revised at the beginning of each school year, if not each term. Problems change with the months.

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Changing conditions in the community, changes in the season, in curriculum, and in administration occasion a shift of emphasis and addition of new activities. As she works, she eliminates some.

At times administrators and teachers may fail to realize as soon as does the nurse, the importance of new demands that arise and of changes needed in established routines. She must then present these new needs so effectively that changes will be made. Often her ability to do this will be directly dependent upon the completeness and accuracy of the information she has acquired through her records of activities and time expenditure.

Approximate time budget. As a preliminary to making the nurse's work schedule, a rough budget of her time is drawn up. This has certain constants no matter how limited her time for work with the school age child may be. She must allocate time for conferences with school administrators, and with teachers, individually and in groups. Parent conferences also are an essential.

Hard and fast rules are impossible in planning these important phases of the nurse's work. General policies worked out in the manual are helpful, but their application will vary from school to school. Commercial polls of public opinion have shown that interviews held in the forenoon or early afternoon bring better results than those of late afternoon and evening, which argues against "after school visits."

Based on past experience and tentative work plans for the coming year, estimates are made of the proportionate time that will be allocated for the various activities.

The nurse can cover essential work more satisfactorily if about two thirds of the school day is unscheduled and free for special activities such as interviews, testing, assisting the school physician, and making home calls. At the same time the most important single consideration in making out an effective schedule is that it must provide for the nurse's presence in definite places at definite times. As a rule such times can be arranged most conveniently at the beginning and end of school sessions.

It is often desirable for her to have her lunch period at an hour different from that scheduled for pupils so she may have conferences

with pupils and teachers at their free time without interrupting classroom activities. She should demonstrate her respect for a proper lunch and rest period in a working day by reserving such a period for herself.

The building in which the nurse has the most work, because of number of pupils or seriousness of health problems, usually serves as her main headquarters rather than one which might happen to be more centrally located. Sometimes she has her first office hour there each morning. In other situations it proves better to have her first hour at a different school each morning. (The hour may not actually be an hour but may vary with the number and type of problems encountered.)

Whenever the nurse leaves her office during unscheduled periods, she leaves directions stating when and where she can next be reached. These are left with a designated secretary or on her own desk, or posted on her door.

The generalized nurse's school schedule. Many of the possible problems that might otherwise be encountered in making out the generalized nurse's schedule are avoided if a good understanding has been reached by her employing agency and the school administrator regarding her activities and responsibilities in general. (See Chapter 5.)

Traditionally a generalized nurse used to report to the school the first thing in the morning. But when a nurse is carrying a nursing program for the entire community and an attempt is being made to have the teachers and other school employees assume an increasing amount of responsibility for health supervision, there are advantages in scheduling her visit for a period later in the day. This gives the teachers and principals opportunity to screen the children who might otherwise be referred directly to the nurse, and their number is reduced considerably. The day's lists of absentees will have been made up and checked against that of the preceding day. Telephone calls accounting for absent children will have been received and

A second point to be given consideration in scheduling school visits for the generalized nurse is that her time for work with the school age child should be left perhaps even more flexible than that of the specialized school nurse. For instance if it is expected that she may have two and a half hours to use for health activities in a certain school on a certain day, only one half hour will be so scheduled. As the demands of her other duties may dictate, she can then spend on school activities the other two hours either preceding or following the scheduled half hour, as proves most convenient.

Every effort is made by the nurse and her employing agency to hold the scheduled half hour inviolate. If the agency employs more than one nurse, it may be the practice to pair off the nurses for the school schedule. Set appointments, including those for school visits, are made at different times for the two nurses so that one may relieve the other for emergency work which might otherwise disrupt her schedule. Care on this particular point prevents one of the most frequently used arguments for specialized rather than generalized service in the schools—"We never know when the public health nurse will be able to come." For occasional unavoidable interruptions the understanding of the school is expected.⁽²⁾

SPECIMEN SCHEDULES

Two examples are given illustrating the problems involved in drawing up a nurse schedule. The first, that of Miss Arnold, shows a "moderate" time allotment; the second, of Miss Bailey, a generalized nurse, a "minimum" time allotment.

Miss Arnold's schedule. Miss Arnold is employed by a board of education in a village. She is the only nurse working in the schools. There is also a public health nurse employed by the health department of the county which includes the village area in her assignment. The two nurses meet regularly (Wednesday afternoons from four to five) and also confer informally and frequently by telephone.

There are 1500 pupils, 225 in two parochial schools and the other 1275 in public schools. About 250 do not live in the village proper and are brought in by buses.

Miss Arnold works a 40-week school year, 5 days a week, and

7½ hours a day, a total of 1500 hours. Her schedule for school visits looks like this:

	<i>Monday</i>	<i>Tuesday</i>	<i>Wednesday</i>	<i>Thursday</i>	<i>Friday</i>
8:30- 9:30	School I	School I	School I	School I	School I
9:30- 9:45					
9:45-10.15	School II	School IV	School II	School V	School II
10:15-12.00					
Lunch					
1:00- 1:45	School III	School II		School II	
1:45- 5:00					

School I is a junior-senior high school with 315 pupils in the junior high school and 250 in the senior high school.

School II has 450 pupils in kindergarten through the sixth grade.

School III is another public elementary school. It has 250 pupils in grades one through six.

Schools IV and V are parochial schools; IV has 125 pupils in grades one through eight, and V has 100 in grades one through six.

This is Miss Arnold's third year in this position. Each year she has managed to reduce the time scheduled for school visits. This program ties up 9½ hours of the nurse's week of 37½ hours of work (like most nurses, she does some work at other times as well). This is 26 per cent of her time so planned. It does not necessarily mean she is in the building named for the entire period. It does mean anyone wishing to locate her during that time would do so through that school. Of course she will spend much time in each school that is not indicated on the schedule.

Of this 9½ hours of scheduled time, School I with its 565 pupils (38 per cent of the total 1500) may seem to be receiving more than its share, with 5 of the 9½ hours scheduled there. However this is the building in which the main health office is located, so all this time is not used for the high school pupils. The nurse makes and receives telephone calls about all pupils and is consulted by the principals and teachers of the other schools by telephone. Also as need arises, some of this time may be used for unscheduled conferences with the superintendent whose office is in the building.

Time budget for administrator-nurse conferences. Miss Arnold has found that she needs to allow about 30 hours a year for

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The same schedules are used for the 7 teachers in the parochial schools using 42 hours.

The nurse tries to meet each high school teacher twice a year in a planned, scheduled conference. (Of course with both secondary and elementary teachers, she has many unscheduled conferences as well.) She meets with 3 or 4 high school teachers together. There are 25 teachers whom she meets in 5 groups twice a year using about 10 hours.

For daily conferences with attendance worker. A daily conference is arranged with the attendance worker who serves all the schools. Although this sometimes requires an hour or two, an average of 15 minutes proves sufficient, requiring a total of about 40 hours a year. These conferences are tentatively scheduled for 9:30 A.M. at the high school, but the time and place are changed according to the cases to be considered. They are held at the various elementary schools at the convenience of the principal or classroom teacher, perhaps after school hours.

For group conferences. Miss Arnold anticipates that she will use on the average 4 hours a week (160 hours a year) participating in group meetings of administrators, teachers, parents, workers of community agencies concerned with the health and welfare of school age children. Some weeks there is only 1 such meeting, or very occasionally none, but other weeks there may be 4 or 5. They seldom last less than 45 minutes and sometimes continue for 2 or even 3 hours. An average of 2 hours per meeting is allocated.

Total time budget for planned conferences.

The year's time budget for scheduled conferences:

With administrators	30 hours
With teachers	220 hours
of elementary public schools	168 hours
of parochial schools	42 hours
of high school	10 hours
Daily conference with attendance supervisor	40 hours
Group conferences	160 hours
Total	<hr/> 450 hours

conference with administrators, which are planned and for which definite times are set. The public schools have a superintendent and four principals; the parochial schools have one administrator whose office is in a building other than the schools.

Monthly conferences with the public school superintendent are scheduled for 2 o'clock the first Monday of each month. These vary in length from 10 minutes to over an hour, so including travel time an average of 40 minutes per conference is planned. Two conferences a year with the same time allowance are planned with the parochial school administrator. There is a teacher-in-charge in each of the parochial schools. They wish to see the nurse on each of her visits to the school but special time does not need to be allotted for the purpose as each would be seeing her anyway in the role of classroom teacher.

The principal of the high school wishes to see her each week so she has a regular appointment with him each Monday at four o'clock. This late hour is set so it will not interfere with a full afternoon's work in the elementary school if that has seemed desirable. An average of 25 minutes a week proves sufficient for this conference.

With the principal of each elementary school a conference is scheduled regularly each month using an average of 45 minutes. The one at School II is scheduled for 10 o'clock the last Friday of the month and the one at School III, as with the parochial school administrator, is arranged by appointment each time.

For teacher-nurse conferences. A monthly conference is scheduled with each teacher. For two of these an hour each is allowed. For the other eight an average of a half hour seems sufficient. One of the long conferences is for the teacher and nurse to review together the individual health records of the teacher's pupils as soon after they have come to her as possible. (See Chapter 17.) The other hour conference takes place at the close of the school year, when they again review the health record cards, using the register and teacher-nurse work sheet as well.

For the 28 teachers in the public elementary schools this requires at 6 hours each a total of *168 hours a year*.

(The classroom teachers in the elementary schools and the physical education teachers in the high schools carry the monthly weighing and spring measuring of the pupils with the nurse participating as she has opportunity.)

During this interview the nurse questions the pupil concerning his activities of the previous summer and discusses with him any questions he raises and also any problems indicated by her review of his record. Using information obtained from him in this manner and also that obtained from his parents on the "Fall Questionnaire" (see page 174) sent to his parents previously, she brings his health record up to date. These individual pupil-nurse interviews consume about 225 hours.

Miss Arnold has found about 72 hours a year are used for audiometer testing. Of this, 50 hours are used for the group screening test, with an additional 6 hours for supervision of correction of the papers and entering the scores on the pupil's individual health records. The remaining 16 hours are used for individual true tone testing and making of audiograms on such pupils as are indicated by the screening tests.

Individual inspection of pupils, advisement of pupils and their teachers, of pupils returning after illness absence or referred by their teachers because of health conditions or called by the nurse for follow-up (see Chapters 10 and 12), use an average of 70 minutes a day or about 210 hours for the total 180 school days in the year. About two thirds of this time is spent with pupils (140 hours), one third (70 hours) with teachers.

Complete time budget

Scheduled conferences	450 hours
Unscheduled teacher conferences	70
Unscheduled parent conferences	180
Pupil conferences	
scheduled	225
daily (unscheduled)	140
Audiometer testing	72
	<hr/> 1137

Out of a total of 1500 scheduled working hours, she is allowing 30 per cent of her time for conferences.

Unscheduled parent-nurse conferences. The first year in her position Miss Arnold found herself unable to budget time for this important part of her work. Now she has much more information from which to work and she can make a fairly reliable estimate although, of course, she anticipates that unusual circumstances alter it frequently. She now knows these 1500 pupils come from 864 families. She must see certain parents repeatedly throughout the year. Others she may have no special occasion to see. The school is aiming to give every child, not just the problem children, a continuous health supervision, and the teachers rely on the nurse to keep up with any changes in family situations. Therefore if a second or a third year is going by with no contact with the family by nurse, teacher, or some other worker, the nurse makes it a point to arrange one. Her average number of parent contacts, at school and in the homes, is 676. These vary in length from less than 5 minutes to over 2 hours (see page 389), averaging 16 minutes and totaling 180 hours or 12 per cent of her time budget for the year. (For other phases of her work with parents see Chapter 12.)

This is a lower proportion than in many nurses' programs. It results from the philosophy of Miss Arnold's school system which emphasizes to the fullest possible extent working through the teachers to the parents in the elementary school and through the pupils themselves to their parents in the older age groups, rather than with the parents directly. There are many instances where it has taken actually more of the nurse's time to secure a desired result doing it that way but it is felt that the additional values gained are worth the extra time.⁽³⁾

Time spent with individual pupils. Preceding each pupil's medical examination if it is to be done in the school, or following it if it is done in the family physician's office, the nurse uses an average of 9 minutes for an interview with him. A few of the elementary classroom teachers test the vision of the pupils. Some of these the nurse retests. All others and the high school pupils she screen tests (see page 183). She inspects, weighs, and measures the pupil.

of school age children with other home calls and does not charge them against the school time budget. Since various emergency demands are made on her time, there is no thought that she will use exactly this much each week, but rather that it will add up to an average of about that for the school year.

Group conferences. In the year's budget of 300 hours she estimates she will spend about 2 hours a week (*80 hours a year*) in group conferences on the health and welfare of school age children with school administrators, teachers, parents, and workers of other community agencies. This amount, though 27 per cent of her total school time compared with the 11 per cent which is the share of Miss Arnold's budget assigned to such meetings, often proves insufficient, and she has to borrow from other activities. She does borrow, however, as she finds it one of the most rewarding uses of her time.

Nurse-administrator conferences. There are certain "overhead" time expenditures which involve essential activities but which have little relationship to the amount of nursing time available. Among these are conferences with the administrator and physician. (Miss Arnold on the other hand works so closely with her school physician, it is unnecessary to schedule special conferences with him.)

The village schools have a public school superintendent, high school principal, elementary supervisor, and a parochial school administrator. The two rural schools are under the county superintendent of schools. Each of the three school "systems" has a different school physician. Miss Bailey assumes there will be a minimum of 2 conferences a month with either superintendent, principal, or supervisor lasting only 10 minutes each, using *3½ hours a year*. No travel time is included as the offices are all in the large school building. The county superintendent and the parochial administrator live out of the area, and since her initial conference with them the nurse's contact has been mainly by telephone and letter. Some years an annual contact only has been indicated; other times, repeated and frequent calls have been required. The demand is so variable, Miss Bailey does not try to budget for it.

Since this leaves only 24 per cent of her time for all her other activities, Miss Arnold is working toward several changes. As the elementary teachers in both the public and parochial schools become more sure of their own judgment on health conditions, she anticipates that the scheduled visits to the schools can be reduced, eliminating some of the time now wasted in travel. At the present, however, this is impossible because of the high proportion of inexperienced and only partially trained teachers. So Miss Arnold is giving priority to any activities that contribute to in-service training for teachers.

There is a possibility that another plan for the hearing testing may be made that will release some of the nurse's time now spent on that. She is also working toward more vision screen testing by the teachers.

Miss Arnold would like more time available for group work with parents and for direct participation in health teaching of high school pupils.

To save on travel time, the nurse plans, whenever possible, to work for the rest of the morning in the school scheduled for the 9:45 call. She aims to spend an uninterrupted Friday afternoon in the high school. In like manner she tries to plan all of Tuesday and Thursday afternoons in School II and all of Monday afternoon in School III.

Miss Bailey's schedule. Miss Bailey is responsible for a generalized program of public health nursing for an area containing 5000 population, including 1000 school children. Of these 50 are in two rural schools, the rest in schools in the small village. One is a parochial school with 150 pupils in grades one through six; there are two public schools, one with 90 pupils in grades one, two, and three, and kindergarten. The other public school has 335 pupils in the kindergarten and first six grades, 210 in junior high school, and 165 in senior high school.

Her time budget for the year. It is assumed the nurse may use about one fifth of her time for this one fifth of the population, which would be roughly $7\frac{1}{2}$ hours a week (a total of 300 hours in 40 weeks). In addition she includes home calls for the problems

is next largest with 15 per cent, so she schedules one visit a week there. School II, with 9 per cent of the total pupils, she plans to visit alternate weeks, and the two rural schools with 2 per cent and 3 per cent respectively she schedules for monthly visits.

While the need for emergency visits to schools arises quite frequently, Miss Bailey does not try to figure a budget for them. Instead she tries to trade time, and have the emergency visit substitute for a scheduled one. This is not always desirable but sometimes works out. Travel time uses from 5 to 30 minutes for each visit.

Activities to be included in school visits. As Miss Bailey prepares for a conference with her supervisor in which they will decide what school activities she should attempt during the coming school year, she wonders how much time she will have for direct services to the pupils. In order to picture this she makes the following analysis of the division of her time.

DIVISION OF NURSE'S TIME AMONG THE SCHOOLS

School	Number of			Total hours	Average number minutes
	Teachers	Pupils	Visits per year	per year scheduled	per year per pupil
I	28	710	80	107	9
II	4	90	20	27	18
III	4	150	40	53	21
IV	1	30	10	13	26
V	1	20	10	13	39
Total	38	1000	160	213 hours	average 13 minutes

This analysis reveals several difficulties but does not suggest any solution. She wonders how much of this time will be left per pupil for direct pupil services when the time used by teacher conferences is subtracted.

Therefore she makes a second table.

Nurse-teacher conferences. Another overhead expenditure of time, which is determined by the size of her pupil load rather than by the amount of nursing time, is that for nurse-teacher conferences. The unscheduled conferences, which are an inherent part of each of her visits to the schools and result from the problems which are referred to her, consume on the average 20 minutes for each visit. The scheduled conferences she cuts down from Miss Arnold's 10 annually to 3. The time for the two "long conferences" to discuss each pupil Miss Bailey tried to cut from Miss Arnold's hour to a half hour, and to use for the third conference a quarter hour instead of Miss Arnold's half hour. The 15 minutes worked out all right for the short conference, but she found her long conferences required even more than an hour apiece. With 38 teachers over 55 hours a year are used for the scheduled nurse-teacher conferences. This is 47 per cent of her year's time budget compared to Miss Arnold's 20 per cent, but such conferences are basic to her plan of work.

Monthly schedule of school visits. Each of the schools want her to visit them each day or at least each week. However of her time budget of 300 hours for the year, group and administrator conferences are using 83 hours, leaving only 217 hours for other school activities. It is obvious that the travel involved would use up most of the time remaining. She has worked out the following tentative schedule of visits:

	<i>Monday</i>	<i>Tuesday</i>	<i>Wednesday</i>	<i>Thursday</i>	<i>Friday</i>
1st week	School I	School III	School II	School I	
2nd week	" "	" "	School IV	" "	
3rd week	" "	" "	School II	" "	
4th week	" "	" "	School V	" "	

Because of other schedules, she does not plan school visits on Fridays. The schedule is laid out according to the schools' 10-month, 4-week period plan rather than by calendar months. It is really a 4-week rotation schedule rather than a "monthly" schedule.

School I is the large village school containing 70 per cent of her pupil load, so she plans to visit it twice a week. The parochial school

In the other three schools the situation is of course still more unfavorable. Also inequalities show up. Four times as much time per pupil is allotted to pupils in School V as to those in School I, and pupils in School IV receive three times as much and those in Schools II and III twice as much as those in School I.

Another serious difficulty, in addition to the lack of time for in-school activities beyond nurse-teacher conferences is this. The time scheduled for school visits, 213 hours, added to the time required for group and nurse-administrator conferences (83 hours) leaves only 4 hours of the total school budget for the year of 300 hours. Four hours will not cover the individual conferences needed with school and family physicians, and dentists, with social welfare workers and other individuals the nurse needs to see in behalf of the pupils.

So Miss Bailey and her nursing supervisor study these schedules to see how the time can be used to better advantage.

It is decided to try scheduling only 3 visits to each of the 2 rural schools instead of the present 10 and to cut School II from semimonthly visits to monthly ones. Eliminating these 19 visits will not only release 36 scheduled hours but will save 7 hours of this time which would otherwise have been required for travel for actual work in the schools. By releasing 36 hours of scheduled time it also gives greater flexibility to the nurse's program and allows her to plan more efficiently. Miss Bailey regrets the infrequency of visits resulting as she knows it will reduce her preventive health supervision but recognizes the wisdom of the readjustment.

Reduction of the number of visits to the two larger schools would probably result in such an increase in demands for "emergency" visits to handle the frequent acute problems arising in them that no time would really be saved.

With the exception of School III, time for work with pupils is still lacking but the situation is improved as there is now in the school budget 40 hours of unscheduled time instead of 4, and when necessary some of it may be used to increase the time used in a scheduled visit. However, other savings must be found.

The nurses decide that the 85 hours now assigned to planned

USES OF THE NURSE'S TIME IN THE SCHOOL

School	Total hours per year	For travel hours	Number of hours used in conferences with teachers during these visits		Remaining time schedule for school for all other activities	Average minutes per child
			Scheduled 2 one hour—1 10 minute per teacher	Unscheduled one each visit 20 minutes		
I	107	13	63	27	4	3/10
II	27	5	9	7	6	4
III	53	10	9	13	21	8
IV	13	3	2	3	5	10
V	13	3	2	3	5	15
	213	34 hours	85 hours	53 hours	41 hours	average 25 minutes

Obviously not even the 10 and 15 minutes left per child in Schools IV and V would be adequate to cover the activities she would like to include such as:

Conferences with individual pupils in school regarding
follow-up of defects

health habits

referrals for suspicion of illness

follow-up of injuries

Assisting the teacher with

vision testing

hearing testing

weighing program

Assisting physician with examinations

With individual parents

conferences at school

notes to them

phone calls to them

Direct services to pupils and school personnel

first aid

retesting of vision and hearing

developing health records

nurse and teachers is wasted because the teachers do not understand just what they should expect from the nurse. Therefore the administrators will be requested to plan a third conference for the teachers, one on health education at which among other things the nurse's legitimate part in this program will be explained in detail.

Some of the teachers have already had the Red Cross course in first aid. An effort will be made to have the others take it, and to include at least part of the janitorial and lunchroom staff members. No better method has been found for reducing emergency calls for the nurse.

Miss Bailey realizes that even if these plans prove successful beyond her most optimistic expectations, her time problem will still be far from solved. If these pupils are a usual group, and she thinks they are, from 500 to 800 of them have conditions needing medical, surgical, or dental attention. And before work can be begun to secure such attention, the pupils needing care must be identified by such time-consuming activities as screen testing, study of children's histories, daily observations, inspections, and medical examinations.

When identification of defects is accomplished and parents notified of their children's needs, if these parents follow the usual pattern, one fifth to one third of them will take action with no further effort on the part of the school. This leaves some 325 to 650 pupils for the school to follow up. In addition to the nurse's ambition to do a nurse's part in seeing these pupils cared for, since Miss Bailey is a well-prepared public health nurse, she would like to have time also for the even more important positive work in the health and development supervision of all pupils.

A frank facing, by nurse and administrator, of the limitations imposed by lack of time will reduce the nurse's feeling of frustration resulting from failure to accomplish what she would like to do in the schools.

USES OF THE NURSE'S TIME IN THE SCHOOL

School	Revised number of visits per year	Schedule total hours per year	Travel hours	Number of hours used for conferences with teachers		Hours remaining
				Scheduled	Unscheduled	
I	60	107	13	63	27	4
II	10	13	2	9	3	0
III	40	53	10	9	13	21
IV	3	4	1	2	1	0
V	3	4	1	2	1	0
	136	181	27	85	45	25

conferences with the teachers can be used to no greater advantage but they wonder if any reduction is possible in the 45 hours now being used by the teachers in the average of 20 minutes per visit, in which they discuss current health problems with the nurse. Miss Bailey never feels she can refuse to talk to the teachers on any subject where they feel her advice might help them. But the supervisor offers to talk to the administrators to see if some in-service health courses might be arranged in the area so the teachers would be better informed and feel more self-sufficient in dealing with health problems. She will also try to interest the administrators in arranging some all-day institutes for the teachers, one on conservation of hearing and one on conservation of vision for the same purpose.

There is a possibility that a voluntary agency may add a health education supervisor whose services would be available to the schools. Both nurses will "talk this up" as they have opportunity, and encourage school administrators and teachers to do likewise. While at the present time the elementary school supervisor directs the health education program in the public elementary schools, the teachers of the parochial school, the rural schools, and the high school come to the nurse for help in their health teaching. There is a certain type of help she feels qualified to give and would like to give if she had the time. Other help is needed by the teachers which she is not prepared to give (see Chapter 4) and which should be furnished by a person prepared in health education. Time of both

*The Nurse's Part in
Individual Pupil Appraisal
and Assistance*

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The Nurse's Part in the School's Study of the Child through the Medical Examination

Inspection, examination, inventory, or appraisal. A number of different terms have been used and are still being used to designate the physician's part in the school's study of the child. Chronologically "inspection" was first and most generally used. This was followed by "examination" in some systems. More recently "appraisal" and "evaluation" have been quite popular. The concept of what the physician's activities should be in the school program have varied as much or more than have the terms to describe them.

Originally and in some schools today, the physician might perform certain isolated activities, and as an individual remain quite detached from the life of the school. He might be "called in" to inspect a group of pupils with the idea of excluding those with indications of a communicable disease. He might "drop in" at an odd moment to give a quick but more general inspection, to list those with any of certain selected "defects." The contrasting plan and one which does operate in some schools today makes the physician an integral part of the school staff, even if only for a part of each day or in a small school for a certain period each week. He does not have to

entire family, rather than as an intensive service to be given him in his school. It is equally well recognized that without some action by the school comparatively few children would receive such periodic appraisal. Even in the case of families and family physicians who subscribe to the idea, some prodding seems to be required to obtain action on it. Other parents who could afford it do not appreciate the value.

Then, for parents financially unable to provide the service, the school must supply it or see that community facilities are available to the parents for the purpose. A community service which supplies examinations and continuous health supervision for all age groups in the family and for the child, pre- and postschool, is obviously to be desired rather than a limited one. This is supplied by family physician, paid by the family usually, but sometimes by the welfare agency, or it may be supplied by a private or public clinic or by the school. In many areas in which such provision is still just the dream of a few advanced thinkers, it seems necessary for the school to supply the present service. This is built around a plan of teamwork between the school, family, and whatever medical resources are available to the family. Observations, history, and the results of tests and examinations are incorporated into as complete an inventory for each pupil as may be attained.

Present practice in regard to medical examinations of school children. Kilander's study ⁽¹⁾ dealt with the examinations required of all students (not those for athletes, or the supplementary examinations for special students and special occasions). It did not distinguish between examinations given by school physicians and those given as part of the school program by private physicians in their offices. It did concern itself with the years in which the required examinations were given.

A large percentage of the schools which reported that they had no "required examination" did indicate (1) that examinations are "offered" but not "required," and (2) that special examinations were given to athletes and others. These special examinations are also given in many of the cities which have the required examinations for all pupils.

be a "full-time school physician" in order to give a regular and complete service, including participation in developing school policies and availability for advisory service when unanticipated needs arise. The school health services developed under such a plan do not aim at taking over parental and family physician responsibilities but at supplementing and complementing them and using them to complement and supplement the health supervision the school gives.

If a true "health evaluation" is to be achieved, a higher type of diagnostic ability and a more comprehensive understanding of human physiology is required than for mere recognition of disease. Required also is a really good health history, which must have built up through the years, and goes far beyond that obtained by the answers on a questionnaire. The functional and structural changes of the child's growth and development are affected by everything which has previously happened to him, as well as by his hereditary environment and his present environment. Since "evaluation" means *ascertaining* the value or amount of something, it is probably too ambitious a label to use to describe what may be attempted in health. "Appraisal," meaning to *estimate* generally as to quality, size, weight, etc., seems a more practical term to use.

Perhaps after all for most situations, "inspection," which the dictionary says is a careful or critical viewing, describes best what the physician really does in the school: "Examination" implies in addition to inspection the idea of "investigation into" and under our present concept of school health service, that is usually considered the responsibility of the family physician or clinic. An expensive duplication of services, and equipment, laboratories, x-ray, etc., could hardly be avoided if the school were to equip itself to "investigate into" the questions that might be raised by the "careful critical viewing" the school physician gives the pupil.

No difference of opinion exists among those who work with the education, health, or welfare of growing children that there should be a periodic appraisal of each child which is as complete and thorough as possible and practical. However, to many it seems more desirable as well as more possible to develop this service as part of a continuous service to the child and as a part of a service to his

were next in frequency, with grades 2-6 being lowest. Many of the schools which reported 4-6 examinations gave the last one in the tenth or eleventh grade rather than in the twelfth grade.

Purpose of the periodic inventory. Its purpose is to enable the school health service to give to the pupil, his teacher, and his family such guidance as will allow them to do those things which will improve and preserve his health and encourage his best growth and development—socially, emotionally, and mentally, as well as physically. Whenever we wait until the symptoms of functional failure appear, and to such a degree that the nonmedical person cannot miss them, the prognosis is more doubtful and the treatment required is greater. For those illnesses which the inventory cannot prevent, recovery is accelerated if resistance has been maintained at a high level.

The value of a periodic inspection or examination by a physician—family, school, or clinic—as a part of a school health inventory is so well established and is so generally accepted as an essential part of the school supervisory process that the health inventory to be discussed here will assume it as part of the program in which the nurse functions.

Since the term “medical inspection” has been too often associated with a too quick and too superficial inspection, the term “examination” will be used, its meaning limited to the type of examination indicated in *Health Appraisal of School Children*.⁽²⁾ Listed are items for the appraisal of which only the physician can be responsible—nutrition, heart (medical), lungs, orthopedic defects, hernia, ears (internal examination), tonsils, nose, thyroid, lymph nodes, glands of internal secretion, and nervous system (organic).

Such examination, whether carried on in the private physician's office (or in a clinic) and followed by a report to the school, or by the school physician in the school building, contributes to the school's appraisal of the child something for which there is no substitute, if the appraisal is to be reliable as a basis on which the school's educational plan for the pupil is to be developed. The school without this sound basis for individual planning finds itself

United States. The information for all cities which reported was, in per cent, as follows: no medical examination required, 17.0; one examination, 18.0, two examinations, 7.9; 3-4 examinations, 21.6; 5-6 examinations, 16.4; 7-8 examinations, 5.0; 9-10 examinations, 1.6; 11-12 examinations, 4.0, and 13-14 examinations, 8.6.

Seventeen per cent of the schools reported that they required 8-14 medical examinations. Many of these schools were actually reporting that they had examinations annually, since some of them did not have school beyond the eighth grade. Those cities reporting 13-14 examinations gave one before the child entered kindergarten and annually thereafter.

The 80 per cent of the 1566 cities which reported that they required one or more medical examinations of each pupil indicated the grade or grades in which the examinations were most frequently given. Of the 260 cities reporting that they required only one examination, 121 indicated that it was given as a preschool examination; 39 reported it as given in the kindergarten; and 87 stated the first grade. The remaining 13 cities gave the examination in other grades.

Of all the cities reporting, 122 indicated that they required two examinations of each pupil during his years in school. Of the 244 examination grades reported by these cities, 37 are given as preschool examinations, 35 in kindergarten, 69 in the first grade; 56 in grades 2-6, 38 in grades 7-9, and 9 in grades 10-12.

There were 196 cities reporting three required examinations of all pupils. Of the 588 examination grades involved, 30 were preschool, 35 in kindergarten, 142 first grade, 166 in grades 2-6, 176 in grades 7-9, and 39 in grades 10-12.

In instances where four or more examinations were required, there tended to be a spacing between the years so as to cover preschool, lower elementary grades, intermediate elementary grades, upper elementary or junior high school grades, senior high school grades, and a terminal examination. The examinations tended to be given more frequently in preschool, kindergarten, and first grade than in any other comparable period. The senior high school years

Increasing the effectiveness of the physician's school examinations—by reducing their number. A continuous program of community education directed toward stimulating parents to take their children to their family physicians (pediatricians if possible) for periodic health examinations, in addition to consultations for illness conditions, will result in reducing the number which must be done in school. It helps to send June letters to the parents of all pupils who are expected to return to school the following September, reminding them of the desirability of visiting the family physician preceding the opening of the fall term. The blank upon which the findings and recommendations are to be returned to the school by the physician may be enclosed or the statement made that such blanks are already in the offices of the physicians in the community. A statement is included of how copies may be obtained if the parent wishes to go to a physician elsewhere.

Reaching the parents of prospective new pupils is not so simple. Newspaper articles, announcements on the radio, and form letters to those with whom the school is in contact are all possibilities. General publicity methods are valuable in that they serve also as reminders to the parents of already registered children who may have delayed securing examinations. In some communities interviewing parents of prospective new pupils is an activity of a committee of the parent-teacher association, and information to this effect is included.

A nurse beginning work in a community which has not been using the plan of having as many pupils as possible examined before school opens will find it is not enough for her to decide that it would be a good idea to do this. The school physician must approve, and then if she can interest the administrator and the school physician in the idea, a group may be called together to make a plan to initiate the practice. Included in such a group would be other members of the health service staff and representatives of local medical, dental, and parent groups. The planning may include preparation of a blank for the physicians to use in reporting their findings and recommendations to the school. *A new copy of the form is used each year, as the cumulative records of the pupils never leave the school.*

running into many difficulties in its attempts to educate children, which are routinely avoided by the school with a more accurate appraisal of the assets and liabilities of its pupils. Children attending school are expected to be able to carry out certain activities. Experience has shown that where no effort has been made to learn if they can do so or not, to learn if they see enough, hear enough, if they have energy enough to concentrate for the required periods, if they are free from pain, if they are free to grow—physically, mentally, socially, and emotionally—there will be economic waste and personal frustrations, of teachers and parents as well as of the unfortunate children themselves, in a certain proportion of cases.

Scheduling the school physician's examinations. The nurse always participates in planning the scheduling, but the actual scheduling after the plan is made may be assigned to someone else. Especially this is apt to be the case in high schools if the amount of nursing service is limited. (See Chapter 18.) Tentative schedules are discussed with teachers whose classes are involved before posting them so they may be adjusted to other special schedules, if necessary. They are then posted (or copies distributed to each teacher) several days before the times chosen.

When the time comes a whole classroom group is not called at once. It may be desirable to call as many as four or five in the first group; then as each pupil returns to the classroom after his examination is finished, he sees that another pupil is sent to the examining suite. The last person sent from the classroom is told to make this fact known to the person in charge of the examining room. In general, a sufficient number of pupils are scheduled at one time so that one is undressing, one is with the physician, one is dressing, and one in transit. If the distance is very great, it may be necessary to have one coming and one going. It is considered more economical to have whatever waiting must be done—and some waiting by someone is unavoidable as not all examinations require the same length of time—by the pupil rather than by the physician and other staff members. But for psychological as well as economic reasons, the pupil's waiting should be reduced by careful planning to the least possible amount.

reported half or more so accompanied by parents for subsequent examinations.

Preparing the pupil for the examination. In a school system with a well-established health service, comparatively little formal psychological preparation may be needed, especially if the medical service is continuous. For new pupils in such a school and for all pupils in a school where the physician's examinations are infrequent or irregularly done, the method and purpose of the procedure needs to be explained by the physician, nurse, or teacher. Any questions the children ask are answered as specifically as possible. The pupils are assured they will be informed the day before the examination, with the qualification if necessary that emergencies in the physician's work may require a postponement. This preliminary notice to the pupil gives him an opportunity to avoid embarrassment by taking an extra bath, wearing clean underwear, and whole stockings. The teacher finds various ways in connection with the regular, or especially planned, classroom work to encourage the pupils to take a proper interest in the examination and to look forward to it with a thoughtful anticipation rather than with the dread which may so easily be associated with an unknown or vaguely described affair. Children whose parents have been invited may be asked to remind them.

Preparation of the examining room and the equipment. Participation in planning for this preparation is part of the nurse's responsibility no matter how limited her service to the school. But no matter how generous the provision of nursing time, she does not consider all the activities in relation to the preparation hers alone to perform. Clerks, volunteer older pupils, and volunteer parents—carefully instructed, teachers with a free period, substitute teachers called in for the purpose, all may be utilized under careful supervision and with detailed planning. Mentally retarded pupils may receive a type of training well suited to their needs and abilities by being directed to do some of the errands and arrangements involved.

Minimum facilities and equipment which are required to do a satisfactory "school examination" include:

At the same time, blanks may be developed for exchange of other information between the school and the family physicians and clinics. (See Chapter 14.)

Increasing the effectiveness of the examinations by having parents present. In the early days of "medical inspection" there was no thought of having parents present during the doctor's inspections. Then there came a period when it seemed to be considered desirable to get parents to come to the school for every examination.

Now there is an intensive effort to get certain parents there. It is becoming the more general practice to insist on the presence of parents of those children for whom recommendations previously made have not been carried out and concerning whom it has been established that lack of funds does not appear to be the primary reason for lack of action. Opportunity is then offered to get at the real reason, to clear up any misconceptions of the pupil or parent, and then to help them make a practical plan for action.

Next in importance is to have present parents of "new" children, either new pupils or transfers from other schools.⁽²⁾ The occasion should be used to encourage the parent to become really acquainted with the child's school in addition to making it an opportunity for the school staff to supplement its knowledge of the child and his family.

The invitation includes a specific time for the examination, and every effort is made to respect the parent's convenience in setting the time. The invitation is signed by the school administrator rather than by the physician, thus stressing the educational significance of the procedure. A reply from the parent is requested. If no reply is received, a telephone call or a home visit by teacher or nurse may help. The fact that not all parents are invited is a factor in securing the acceptance of those who are invited.

Kilander's study⁽³⁾ showed that only 14.2 per cent of the schools reported no parents present at the pupil's initial entrance examination and 52.9 per cent reported more than half of the pupils accompanied by a parent for this first examination. Only 9.3 per cent

group. A parents' committee may assume responsibility for them. Constructive publicity for an improved medical examination and greater appreciation of the service by pupils and parents may be concomitant to the activity.

Some physical education uniforms are of a type satisfactory for the purpose.

Removal of clothing. There are many misunderstandings among school administrators and even among health workers regarding legal aspects involved in removing a child's clothes in school. Unless there is a special mandate in state law or local regulations forbidding this, it is unnecessary to ask the parent's permission or to contrive to have the parent "request" it, as is required whenever any treatment or test is to be given the child which so much as breaks his skin.

When medical examinations are required or permitted, it is assumed that this involves seeing the child and not his clothing. However, if removal has not been the practice in a certain school, it is much better policy to inform all parents of the new plan. Any who are not in sympathy with the idea are informed that it can be avoided if they take their children to the family physician for the examination as the school has previously urged them to do. But the procedure is established that school examination is to be made with the clothing removed. Parents who accept the invitation to be present are soon reassured as to the reasonableness and decency of the procedure.

A woman is always present when girls are examined by a male physician—for the girl's self-respect, the reassurance of the parent, and the protection of the physician. If the mother is not present, this woman may be a classroom or substitute teacher, a matron, an adult volunteer, or the nurse.

Kilander's study ⁽¹⁾ showed that in both elementary and secondary schools more clothing was removed from boys for the examinations than from girls. Boys were reported as "entirely stripped" by 8.0 per cent of the elementary schools and 9.1 per cent of the secondary; while for girls the per cents were only 6.4 in the elementary schools and 4.5 in the secondary.

Enough space for privacy for the examination and consultation; arrangements for the child to undress and dress again out of sight and hearing of the examination and consultation; place for children and parents to wait out of sight and hearing.

Adequate heat, light, and ventilation.

Hand washing facilities in the room convenient for the physician's use as he is examining; toilet and hand washing facilities nearby for pupils.

Chair or stool and table or desk for the physician.

Stool for child being examined and cot, examining table, or couch for abdominal examination.

Chairs for parents and teachers.

Tongue depressors with containers for clean and soiled equipment.

Otoscope, extra tips, basins for disinfection.

Stethoscope.

Such additional equipment as may be specified by the physician for additional examinations.

Examining robes for older girls.

When no curtained or partitioned cubicles or dressing rooms are available, screens may be used to supply privacy. Sheets or blankets hung over wires are another possibility. The spaces may be quite small, large enough only for the child to move about and to include a chair or rack upon which the clothes he removes may be placed.

If the room in which the physician examines lacks a lavatory, provision of a basin, water pitcher, and waste pail is essential.

The examining robe for older girls can be very simple. A square of material with an opening in the center large enough for the head to go through is practical and inexpensive. Or halters may be made by cutting a square yard of material into two parts diagonally. The right angled corner may be cut off or hemmed back and tapes attached. Unbleached muslin, seersucker, or percale are materials most commonly used. A towel, at least 18 or 20 in. by 30 or 36 in., with tapes attached to each corner or fastened by a chain with clips such as dentists use will do.

The most important requirement is not the type of cover which is used but that it is used only once and then laundered.

Planning for and preparation of a set of these covers makes a good project for a home economics group or an extracurricular

jury, illness, operation, or treatment the child has had since entries were last made and the results of any tests or immunizations not previously reported. Is there anything more the school should know about the child in order to adjust or modify his school program? Has he had dental examination or treatment, change of glasses, or any treatment for any other condition reported or not reported to the parents by the school? A question about care for allergies may yield valuable information. Each year the name of the "present" family physician is requested to be sure that the one listed is the current one. If both parents work, or attend school, the question is repeated as to the name of a relative or friend to whose home the child can be taken if he becomes ill in school—and how such a person can be reached by telephone. This is another designation which may change year by year—or oftener. The present address of the child is checked. For children from broken homes it may be necessary to check also for changes in guardianship.

For a pupil who attended another school the previous year and it is found that his health record has not been received, it is necessary to find out where he attended and send to that school for his health record. (See Chapter 14.) In the meantime, if necessary, a temporary record may be made for the physician's examination as it is desirable for the child to be examined as soon as possible. When the previous record arrives, the data from the physician's examination may be copied on it, unless the blank is so dissimilar to that used in the present school that it either will not fit in the files or does not allow recording the type or amount of information required by the present school. In such a case, the history but not the examination record is copied from the old card to the new, the old record is stapled to the new and the record continues on the present school's blank. Previous addresses and names of schools previously attended should not be erased from the record as they may prove helpful if future circumstances make it necessary to trace back and secure additional information about the child's or the family's history.

For pupils who have never attended any school before, a new card is started. The identification should be filled in by typewriter or careful hand printing. This information is obtained from the

"Stripped to the waist and shoes and stockings removed" was reported for boys by 24 per cent of the elementary schools and 18.8 per cent of the secondary schools; for girls 20.6 per cent of the elementary schools and 15.3 per cent of the secondary.

"Stripped to the waist only" for boys was reported by 18.9 per cent of the elementary schools and 17.1 per cent of the secondary; for girls by 15.5 per cent of the elementary and 13.9 per cent of the secondary.

"No clothing removed" was reported for boys by only 5.7 per cent of the elementary schools and 3.8 per cent of the secondary; for girls by 6.1 per cent of the elementary and 5.3 per cent of the secondary. The remaining schools either removed outer clothing only, shoes and stockings only, or had "no set policy."

Presence of the nurse at the examination. A nurse giving a minimum service in a school will be present at the examinations as much as she can, but even in the case of a nurse with the most generous amount of time, the planning should not be on the basis that she will always be there.

She confers with the administrator and physician, individually and jointly, to plan the procedures to be used. By having all the materials and equipment on hand and conveniently arranged for use, she will help greatly in making the experience a satisfying one for the physician and a valuable and comfortable one for pupil, parent, and teacher. She herself has a good opportunity on this occasion to learn the problems of the child and to work toward desired results from the parent in the way of cooperation and follow-up on the doctor's findings. The work must be planned, however, so that some of her time is free during this period for observation of the physician's work and for consultation with the pupil, parent, and teacher. If she is attempting to weigh and measure pupils or test vision during this time, the main values of her presence along other lines are lost.

Bringing the records up to date before the examination. For pupils who have attended the school previously, this involves adding data obtained from the parent and child through interviews and through a questionnaire. Inquiry is made concerning any in-

back to review previous findings and review the illness absence record and health and family history. He is relieved from the necessity for dictating his findings in front of the child with the possibility that the child will be worried about them and perhaps misinterpret them. He can be certain that his findings and recommendations are worded and recorded just as he prefers them to be. If, as is increasingly the case, the record is required as evidence in a legal action, perhaps years later in the case of a compensation case, the record is sufficient, if in his own writing, signed by him and properly dated, so that he does not have the inconvenience of being required to appear in court. He also avoids the embarrassment which might result if he were unable to recall the individual child, to identify his findings, or to be sure that they are recorded just as he dictated them.

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affected by the amount of follow-up service by teachers, nurse, and social workers and by the adequacy of professional services, paid and free, in the community.

Although a pediatrician usually considers he must "see" a child at least semiannually if he is to be considered to be giving him the health supervision needed, the American Medical Association in recognition of personnel limitations recommends a periodic medical examination for the school child "every two or three years."⁽¹⁾ Not even this infrequency has yet been attained in the majority of schools today, and the prospects are not bright for its realization. Therefore, continued research is indicated to develop effective screening tests which can be used to pick out earlier than we now do those children who will later develop physical, mental, emotional, or social difficulties.

The school situation is a "natural" for the application of screening procedures. Unless medical personnel becomes available for school services in much larger amount than is now indicated, it would seem that transition of the school health program from its corrective-remedial nature of the present to the so much talked of positive-preventive type will have to depend largely upon development of more screening procedures which can be effectively, economically, and quickly used in the school and which can be manned by a technically, not professionally, prepared staff. In the dental area this has been worked out through the preparation of dental hygienists whose original preparation to work in a dentist's office is supplemented by additional preparation for those who are to work in the schools.

The nurse needs an open mind for the consideration of any new screening tests proposed for her school. But her eye must remain critical as she views results, not only of new programs but of the old ones as well. The fact that a screening procedure has been examined under laboratory condition and found reliable, or that it has produced reliable results in other school situations, does not guarantee that its results will be reliable in every situation. One check which can be used is the frequency of confirmation of the findings by diagnostic procedure. Another is the acceptance of the

The Nurse's Part in Screening Programs

Selection of screening procedures for school use. The nurse may or may not participate in the actual screening processes but she is usually expected to be well informed concerning the various methods used and to be able to give a well-qualified opinion on the applicability of any certain test to the particular school group. After tests have been given she helps evaluate the results of the process.

To keep herself informed on current developments in screening methods requires a continuous review of professional periodicals and a frequent check with the organizations especially concerned with the fields in which the screening is used. In most states now, a basic minimum screening program is required by law. She must be sure she has accurate information on such requirements.

A health program changes from a remedial program to a preventive one as two gaps are closed up. One is the gap between the time the child begins to develop an abnormal condition and it is discovered. The other is the gap between the time it becomes known and something is done about it.

The first gap is reduced in direct proportion to the frequency of medical examinations given the child. The preparation of the physician for work with children and his experience with them also increases early discovery. The second gap between the time a condition is discovered and the time something is done about it is

. . . lack of facilities for treatment and care should not be considered a bar to beginning a program of screening, as a matter of fact detection demonstrates, provides the facts necessary for development of treatment and rehabilitation program.

This philosophy is particularly applicable to the school age group of whom a certain proportion are dependent upon society for care and upon whom, with the rest of the school age group, society will be dependent in another decade or two. After each war with its revelations through draft examination findings of the neglect of childhood health, there is an increased impetus toward remedying the situation so that the youth of the country in the next generation will be more ready to meet the demands which will be made upon them.

There are three restrictive influences which limit the school health activities designed to locate earlier than we do now those pupils who will later develop physical, emotional, or social difficulties. One is pupil time. Another is the time of school personnel used to administer the screening processes. A third is the cost of special training and equipment required. Some health specialists, enthusiastic in their concern for certain phases of the health program, disregard the item of pupil and classroom teacher time and consider that if a procedure can be arranged so that the regular teacher can carry it on, there is no "expense" involved. A large majority of the school children in this country are attending school for a shorter term than is considered desirable because of lack of funds to provide a proper amount of time. Calculation of the "value" of each pupil's every hour or every minute in school can be easily arrived at. The number of pupils in average daily attendance is multiplied by the days school is in session, then by the hours or minutes of instructional time each day. The total cost of the schools for the year is divided by this figure giving the cost per pupil per hour or minute.

When all pupils in a teacher's group can be tested at once, the cost per pupil is, of course, only a fraction of what it is for the test which a teacher must give each pupil separately. If the pupil time used must include for each test, the time of the others in the group who are losing instruction while the teacher works with an individual, the expense must include the cost of time lost by each of

results of the screening by those who are tested, by the parents, and by the professional group in whose field the screening is applied. Failure on this score may have nothing to do with the screening itself and may rest entirely on the school's failure to educate the community. Material factors influencing the success of a screening program include ruggedness of the apparatus used, availability of repair service, possibility of transportation, and amount of space needed to set it up.

Some screening procedures are properly evaluated by the number of cases, previously unknown, which are discovered; in others this might not be the deciding factor. Application of this standard in deciding the age group to be screened would usually indicate moving the programs out of the school and testing adults instead as the findings would be so much larger. But such postponement too often means that when the conditions are found, the best time for economical and effective remedial measures has gone by.

In some instances parents may find screening results more acceptable than what to them is the "personal opinion" of the teacher or nurse that a child is hard of hearing, has poor vision, or is poorly nourished. The mechanical measurement by an audiometer machine or by some of the impressive vision-testing equipment of the Massachusetts testing plan, or a laboratory test, carries a definite weight.

The matter of cost is another item which must be considered in determining screening operations for school use. Cost may be estimated as per pupil tested, per case discovered, or per case put under treatment. For school purposes cost per pupil tested is usually the most appropriate to use. For pupil guidance positive facts may be as valuable as negative ones; it is valuable to "know" that an individual is free from tuberculosis, that he can see and hear normally, that he is not particularly neurotic.

Cost per case put under treatment is the last to be used, as it is well known that, in general, community facilities are inadequate to care for many of the conditions found in school children. Establishing the number for whom treatment is needed and unavailable may be a requisite step in developing the needed services. Hilleboe says:⁽²⁾

through all the school systems of a certain area, such as a county or a state, may serve a double purpose. The first, of course, is to discover the children who need further study and perhaps treatment; the other may be to focus the attention of the entire community upon certain needs which are not being met. In an area where too little has been included in the school health program in the past, such focusing of attention on one new service at a time may have a distinct advantage. For instance, screening for vision difficulties may be given first place, followed by hearing testing, then dental inspection, and later by a screening for postural and orthopedic defects. The program for discovering nutritional problems may be left till among the last as it lacks some of the features which make a screening program satisfactory for the purpose of community demonstration. A tuberculosis case finding program is carried out whenever it proves possible to have it, since it touches only selected age groups and depends on the availability of community facilities for it which usually come from without the school.

Often weighing and measuring are carried on as a part of the regular classroom program and are not considered a "screening" process. They are an essential part of the data required for each child's health appraisal, however, and may be used in screening.

A survey to determine the amount of retardation is not usually considered within the nurse's responsibility to arrange, but data from it are important to her study of individual pupils.

Likewise a general screening to determine speech defects is usually considered the responsibility of a member of the instructional or administrative staff, but here again the findings are essential to the appraisal of the individuals.

Another survey of great importance but often out of the realm of the school's provision is a cardiac survey. The screening for this is done by physicians. They refer children with indicative conditions to a cardiac clinic where special equipment and consultant service are available for determining which children have active heart disease.

Screening for visual difficulties. Many states have laws requiring an annual vision test for children already in school. But the

the others in the classroom. The item of teacher and pupil time, therefore, is one which must always be considered in deciding by whom and how a test is to be given.

Screening which only the teacher can do. There is no choice but that upon the teacher must rest the first line of responsibility for screening out the children in whom there has occurred an abrupt change in physical or emotional condition. The signs and symptoms of the onset of a sudden illness, including most of the communicable diseases of childhood and the evidence of an injury or an emotional upset which should have attention, must be noted by the teacher at the earliest moment possible and the child referred for necessary attention. (See Chapter 12, "Day-by-day Health Supervision of Pupils and School Personnel.") The specialized members of the health service staff, especially the physician and the nurse, may be of help to the teacher in developing her sensitivity to variations and in improving her judgment concerning appropriate action to take when they occur, but they cannot do this screening for her; she is the one most usually with the child when this sort of a need arises.

Inspectional screening by others than the teacher. There is no implication that the teacher has failed to meet her responsibility for pupil inspection when her inspection is supplemented by that of others. The dental hygienist's inspection of the teeth and gums is supposed to go far beyond that expected from the teacher. The nurse's inspection of a group of children recently exposed to a communicable disease should be able to find signs and symptoms not yet obvious enough to attract the less experienced eye of a teacher who may never have seen a child ill with the certain disease being looked for.

None of these three workers with children need be embarrassed that a pediatrician's inspection may sort out children with malnutrition, a glandular disturbance, or a nervous condition which escaped her eye. The nurse may find a posture case the teacher missed, and the physical education teacher may note one that the nurse failed to see.

Special screening programs. A screening program carried on throughout an entire school system simultaneously or perhaps

ments and emotional disturbances from their reading failures which might have been prevented by proper testing and treatment before the use of eyes for fine work is attempted.

Identification of those with poor color perception is essential before or early in kindergarten life as so much of the activity in kindergarten involves work with colors. The sense of failure and inadequacy which follows when a kindergarten child finds himself unable to do the things his associates manage without trouble causes emotional disturbance as great or perhaps greater than those resulting from comparable frustrations in later life. If it is impossible for the school to employ sufficient medical, nursing, or technician service to provide these tests, the nurse looks for a volunteer to train for this important function. The one chosen must give definite evidence of a degree of ability, reliability, and interest to warrant the time required to prepare her for this work.

Oberteuffer says: "Where such persons are employed [the physician and nurse] they should be given ample time in the schedule to do a thorough screening job."⁽¹⁾ If they have time to do part of the screening and a volunteer is used for the rest, it is these entering children for whom the most expert service should be used. If the right volunteer has been chosen, she may prove to be better than the regular staff, if the latter are subject to frequent interruptions.

Research concerning provisions for vision testings. The St. Louis study of vision testing was sponsored by the National Society for the Prevention of Blindness, the United States Children's Bureau, the Missouri Division of Health, and the St. Louis Board of Education. It was designed to secure data that would be helpful in answering questions concerning the screening devices which should be used; by whom the testing should be done; and how frequently it is productive to retest children previously testing normal. Results indicated that none of the six tests used provided more than a rough screening procedure and that they would not justify positive statements to parents about visual defects.⁽²⁾

Screening devices for vision testing. Of the many methods of testing vision which have been used in schools, there are four which

most important time for a child to be observed, tested, or examined to discover conditions which may interfere with his normal vision is, of course, before he enters school. (See Chapters 11 and 17.)

In her own mind the nurse's aim is to have every child who enters school come with an ophthalmological examination. It may be years before this is a requirement, but in every community there are a small or large number of parents who can and will obtain for their children that which they are convinced is needed. For these children at least such an examination should be obtained. The nurse joins her efforts with those of other individuals and with groups or organizations, interested in health, child welfare, prevention of blindness, or any other related subject, that may be considered to have an interest in protecting children's eyesight from one point of view or another, to work to educate parents and agencies concerned with children as to the value of such an early examination.

Ruedemann says: "Every child should have his eyes refracted under atropine before he enters the first grade, so that he can be protected against abusing a pair of inadequate or deficient eyes."¹

For children for whom this professional examination proves impossible of attainment there are other measures of less expense (and less completeness) which are of considerable value, nevertheless. One is an inspection in infancy to identify and secure follow-up care for observable cases of muscular imbalance, supplemented by simple tests for imbalance of a lesser and not readily noticeable degree when the child is three or four years old. Some children receive such observation and tests from their family pediatrician or physician. Others go to a well-baby or well-child clinic for the supervision. But for the great majority, there is no consideration given the preschool child's vision unless he has a most obvious defect. Even then some parents may feel no action need be taken until he "goes to school and has to use his eyes."

If these children are unfortunate enough to enter a school where there is a practice of waiting to give even the most elementary test until the third or fourth grade when "they will know their letters and be easier to test" a certain proportion of them will suffer not only possible additional visual damage but also social maladjust-

ments and emotional disturbances from their reading failures which might have been prevented by proper testing and treatment before the use of eyes for fine work is attempted.

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and indicated treatment earlier. Or as another alternative, he may give up using his eyes very much and become poor in his school work though "bright enough at home."

The nurse may come in for considerable criticism from both parents and eye specialists when she follows up borderline cases and is successful in getting the parent to take the child to the ophthalmologist, only to have him find that the child has eyes which test normal with the physician's more accurate testing methods or that the defect is a minor one for which no treatment is recommended at the time.¹⁴ But unless the school (or parents or community agencies) provide ophthalmological examinations, marginal cases must be referred, if the borderline cases are to be identified. If the specialists in an area or a committee designated by them work with the health service to establish the standards by which the decisions for referral or nonreferral shall be decided, they will understand why needless referrals are made and be more patient in explaining to the parent why such referrals are unavoidable if their children are to be given the best protection by the school.

It is more simple to set a standard relating to visual acuity than in regard to other possible indications of variation from normal. 20/20 is commonly accepted as normal for adults, but even in late adolescence 20/10 may be a more usual average. In young children 20/40 may be accepted as satisfactory by the committee if it is considered that the children are under sufficiently intensive and intelligent supervision that any ocular symptoms and signs will be observed, reported, and acted upon at once.

Screening to discover impaired hearing. The plan to be used in screening for hearing impairment may be dictated by state law or regulation. In that instance the nurse has the responsibility to be sure she is properly informed as to the technical details of the requirements and her own place in the carrying out of the complete program.

If audiometer testing is new to her, she will obtain reliable material on the subject and supplement her reading by observation of a well-trained technician. This is essential even if she is to do none of the actual testing. The effectiveness of her follow-through

lighted otoscope. If this is not the case, such an inspection is sought before a child is referred for further audiometer testing or otological study, and if any traces of wax are observed, its removal is secured and a retest done before any other follow-up is attempted.

Careful inspection of children who have "failed" the test will reveal some who have indications of an acute or perhaps chronic upper respiratory condition that may be related to the failure to hear normally. If follow-up is delayed until the condition has been cleared up and the test repeated, it may be found that the failure to hear has cleared up too.

As is the case with vision failure, in hearing failure there are the two matters to be considered—how much can he hear and not hear, and how well does he use his hearing in actual communication? Here again it is vital that there be mutual understanding between the school staff who are doing the referrals and follow-up and the specialists in the area to whom as family specialists or as clinic workers the pupils are being brought for diagnosis and treatment, as to the basis for referral. In a city system, such an understanding may be arrived at by consultation between the school medical director, the health department, and the heads of the various clinic services for the city, perhaps supplemented by the chairman of the otological group of the local medical society.

In rural or semirural areas, if schools are without medical direction, it might be possible for a county organization of school or public health nurses to ask for a conference with a representative of the otological group to clear the thinking of the nurses and stimulate the establishment of consistent procedures throughout the area served by a certain clinic or a certain group of specialists.

Surveys to identify children with speech defects. The nurse participates in carrying on such a survey less often than in vision and hearing surveys. She does, however, have a great interest in helping to direct attention to the desirability of finding these children and doing something about them, and she has much to offer in helping remedy some of the conditions which intensify or perhaps even cause certain of the difficulties.

Johnson estimates that about 5 per cent of the school population

to obtain action by parents, family physician, and otologist will depend on her ability to interpret the findings to the parents, plan with the family physician for the next steps in obtaining the full battery of clinical audiologic tests, and the necessary examination by an otologist. If the school does not include speech tests in its own services, these must also be arranged for outside, as needed.

If the nurse is working in a school system in which there is no plan for audiometer testing and the state has no requirements, she has an added responsibility for the education of school officials, parents, and the community, as to the efficiency, economy, and necessity for periodic screening to discover children with hearing difficulties. It is safe for the nurse to assume that about 5 per cent of the children in such a school have impaired hearing. Some of these children are known to their parents, family physicians, and the school without a special finding program. But when this number is subtracted from the 4 or 5 per cent that are probably there, it can readily be seen that a testing program is needed.

An estimate of the time required for the whisper test, and that used in the group audiometer test, combined with the comparison of the findings, and as a last step, combined with a comparison of the reliability of the findings, furnishes convincing data to show the economy of the machine test.

The sweep test with the pure tone audiometer furnishes equally or even more convincing data with effectiveness, economy, and reliability. (See Chapter 11 for more detail.)

Research concerning provisions for hearing testing. Before a new nurse makes any recommendations concerning installation of a testing program or changing of an established program, she will wish to obtain the latest material available from such organizations as the American Hearing Society ⁽⁷⁾ and the Volta Bureau, ⁽⁸⁾ regarding current recommendations as to the most desirable type of testing program. Through development of new machines and the findings of additional research, the procedures considered best today may be greatly improved tomorrow.

Standards for referral of cases found by screening. In some schools eardrums are routinely inspected by a physician, using a

birthday, with treatment of all dental defects during incipient stages. He will have had a series of four treatments, within a period of two or three weeks during his third year, of sodium fluoride as a partial preventive of dental caries.⁽¹¹⁾ For this child the school needs to have no program to determine his oral health status. There are occasional schools in which a large enough proportion of the pupils have this kind of care so that a general school program is not indicated. Individual plans for the children needing care they are not obtaining are sufficient.

But in the usual school there are from 50 to 90 per cent of the children found to be suffering from dental disease of one type or another. It is estimated that there are approximately 7 to 8 million children in the United States of the forty million under the age of 16 years who need major orthodontic care; that less than 4 out of every hundred are actually receiving treatment.⁽¹²⁾ The ultimate purpose of the school is to educate pupil and parent to know and desire good dental care, and to have available in the community sufficient facilities to meet the needs both of those who can pay and those who cannot. Educating them to want and to seek care would be a greater accomplishment than if the school were able—which most of them of course are not—to provide a complete diagnostic and treatment service for all children and this were passively accepted by parents and children.

School dental programs vary from practically nothing to what is a complete service, usually, of course, for a very limited number of pupils. A more general practice is to use the results of a school examination by a dentist or a dental hygienist as a means of arousing the parent's concern to stimulate him to seek care needed through the family dentist or a clinic outside the school.

The nurse's part in dental screening. The examination of teeth by physician, nurse, or teacher is considered unproductive from a clinical point of view as without specialized skill and the use of mirrors and explorers many indications of trouble are missed. Negative findings then give those to whom they are reported a false sense of security.

This does not preclude sending of recommendations for dental

have a speech difficulty though they are physically and mentally normal. About half that number because of a handicapping condition, such as a cleft palate, hearing loss, or cerebral palsy, also have speech or voice problems.⁽⁹⁾

Speech correction is a relatively new field and there are too few well-trained speech correctionists available. Some school administrators are fully aware of the need and seek properly prepared staff for this important work for the handicapped; others seem unaware of the need. The nurse will always find a certain few people in any community whose interest can be directed toward a group of children needing a particular kind of help. Adults who have endured such a handicap, parents of children with noticeable difficulties, and teachers with a special interest or special preparation will be ready to work with her to develop a program to identify and later to develop some facilities to help the pupils in this group.⁽¹⁰⁾

If no other possibility exists, the case finding can begin with the nurse's request to each classroom teacher, when she is interviewing the teacher preparatory to the examination by the school physician of the pupils in the teacher's group, for the names of the pupils who show some type of speech difficulty. In the course of her conversations with pupils, the nurse may find some herself. These then can be brought to the physician's attention as he examines the pupil. In some cases the trouble may be related to a physical condition and follow-up begun on that basis.

The number of pupils found with speech defects by this casual method will be far under the expected 7 or 8 per cent, but each one identified means one step taken toward doing something about his problem and eventually about the problem in general by an increased recognition of its existence. (See Chapter 11 for additional material on this subject.)

Screening to determine oral health status. A child coming from a family interested in and able to follow the recommendations of its dentist for desirable dental supervision will be able to present a dental history for the school record which will make unnecessary any school screening procedure. Such a child will have had dental examinations three or four times yearly, beginning before his third

blotter to photographs or silhouettes against checkerboard backgrounds.

Classroom teacher, physical education teacher, nurse, physician, and parents all have some responsibility in this as in other fields of observation of the children they work and live with. If even occasionally it is possible to bring into the school an orthopedist to screen the apparently normal children for discovery of incipient variations, the sensitivity of these day-by-day workers is improved.

A plan for the physician and physical educator to pool their observations and to confer on referrals, as well as on corrective exercise to be given, may also be utilized to increase the sensitivity of the teacher and nurse to significant variations. The teacher's function in this program is as described earlier in this chapter and in Chapter 12, "Day-by-day Health Supervision of Pupils and School Personnel." It is to note any change, sudden or gradual, in the child's posture, or in the way he handles himself. An unusually observant teacher may note a child who is developing a limp before his own parents observe it. An experienced principal may "pick out of the line" on the first day children return from vacation a child with a slight paralysis from a missed case of poliomyelitis.

But in this difficult field of posture and orthopedic evaluation, too much must not be expected of the teacher. However, with the right kind of help from the nurse, physician, and physical education teacher, the teacher who continues for a number of years to work with a certain age group can see her own ability increase from year to year as she becomes able to pick out children on their way to develop a postural or orthopedic defect.

One thing that is a definite help to her in developing such an ability is to have the assistance of the nurse, physician, and physical education teacher, as each new group of pupils come to her, in learning what the already existing variations from normal are among them and the significance (or insignificance) of each one. This gives her much more self-assurance in referring children who seem to her to be developing some peculiarity. She does not have to wonder—"perhaps he has been that way all the time and I just failed to notice before."

care to parents on the basis of need whenever it is observed by one of these three—physician, nurse, or teacher; these are sent as incidental observations and not as a result of an "examination" which others "passed," as interpreted by omission of notices to them.

In some schools the examination by the dentist or hygienist is supplemented by x-rays when indicated. This is an essential if the plan is to inform the parent of just what service is needed. Many difficulties are encountered when this plan is used. In other schools the policy is to send the parent only a general statement that there are indications that the condition of the child's teeth and gums make a visit to his dentist necessary, without specifying whether there is dental caries, need for prophylaxis, extraction, prosthetic appliances, orthodontic treatment, or care for diseased gums.

The simplest school program is the one which is confined to determining whether the child has been seen by his dentist within a stated period (which the local dental group may well have a part in setting) and if he has not, concentrating all efforts on getting him there as soon as possible. This program has many advantages, but until it is established in a school that all the pupils are receiving continuous dental supervision from a family or clinic dentist, the school needs to continue to make at least an annual survey of the oral health status of each pupil so that summaries may be compiled and the extent of the need for additional community facilities be accurately known. Without such information there is little hope of remedying the situation.

The need for such summaries is so well recognized that many states require that the figures regarding the number of pupils with dental conditions needing treatment be sent as part of the school's annual report to a state agency along with the number which have received adequate treatment. The long period of time which usually must elapse before an appointment can be obtained with a children's dentist, whether in the family dentist's office or in a clinic, is concrete evidence of lack of adequate facilities on both financial levels.

Orthopedic screening. There are many types of apparatus designed for such screening, ranging from a simple footprint on a

to observing and recording on each individual's record all obtainable data relative to his growth and development in order to refer for medical attention any child concerning whose nutritional status there may be some question. (See Chapter 12.)

A minimum record is the recording of height and weight three times a year: monthly or at least bimonthly recording of weight is preferable. The interpretation of the significance of the figures recorded is more meaningful if the data are plotted on specially constructed charts such as those prepared by Howard V. Meredith⁽¹³⁾ and Norman C. Wetzel.⁽¹⁴⁾

Medical screening tests. At one time or another, practically every test has been used on a school population at least once. Dick and Schick tests are no longer advised for general use. Diphtheria cultures, tests for hookworm, typhoid, and paratyphoid may still be ordered under special circumstances but are not used otherwise. Urinalysis and blood pressure, as well as blood tests for anemia, may be used now and then. Under very unusual conditions, testing for syphilis is indicated.

But the case finding program concerning which there is the most general agreement as to the appropriateness of its use in the school is that for tuberculosis. In a few states it is mandated but if it is not, there is apt to be a recommended program set up by the state health department or a state group concerned with prevention of tuberculosis or, ideally, by the state education department in co-operation with these two agencies. If this is not the case, the nurse will find out what the local program and facilities are and work within that framework of planning. It is not her responsibility to say whether tuberculin testing, fluoroscopy, or chest x-raying is to be used; nor is she the authority to decide what age groups are to be surveyed. It is her responsibility to do all that she can to see that much emphasis is put on the program for all school employees.

If there are a considerable number of cases of any of the skin and scalp diseases, such as ringworm of the scalp, athlete's foot, impetigo, pediculosis, or scabies, present in the pupil group, a school-wide survey in which every child is inspected by the physician or nurse, repeated at intervals, may be desirable. If there are few cases but

The significance of flat feet, of toes which point in or out, of bowlegs and knock-knees, and even of "round" shoulders, has proven debatable. This is evidenced by discussions by the experts comparing some of the findings in the draft examinations, with performance results. Therefore, unskilled people are asked less and less for referrals on them. There is, however, another type of survey within the realm and interest of the usual classroom teacher, which has a value from an orthopedic point of view. This is a periodic survey, at least once a year, of the fit of shoes and stockings. Summaries of the findings can be used to stimulate interest of groups. Referral to each parent of the findings on his children is used to interest him to improve the situation. In the usual school, where there are various economic groups, publicizing the need for outgrown shoes and overshoes may serve to profit both groups. An appeal to the well-to-do, to check to see if there are not some which their children have outgrown may result in new and better fitting ones for them.

The nurse's part in orthopedic or posture surveys. If there is an orthopedic service available, locally or through state auspices, the conscientious nurse will use every method she can to interest the school authorities and the specialists in that service, in planning a complete survey of all pupils in the school or, if that is impossible, of certain age groups each year. If that is not possible, she will not name as a "survey" any inspectional activities that go on in order to avoid, what has been mentioned so frequently, the false sense of security that may be given concerning those who are not spotted by the "survey."

The nurse will utilize every opportunity to increase her own familiarity with early signs and symptoms of orthopedic variations, not only through her reading but by visiting clinics where experts are at work.

Surveys to determine nutritional status. Until more definite and accurate as well as economic and easily applicable tests to determine nutritional status are made available for school use, summaries of findings and publicity concerning the per cent of children with good or poor nutrition will probably be avoided by most schools. At the same time, more and more attention is being given

If a special survey seems required, it should be done as thoroughly as possible, by physicians and with the pupil's clothing removed as for a medical examination. For good public relations and also to salvage some of the considerable expense involved, and to obtain some positive results, the inspection might well include an orthopedic inspection in addition to that required to locate drug users.⁽¹⁵⁾

Staff education of all school employees as well as of teachers should give specific instruction regarding actions that might be indicative as well as physical and emotional signs and symptoms.⁽¹⁶⁾

Surveys from a study of records. In this group, illness absence surveys are especially valuable. Surveys to note the identification of and total number of accident-prone pupils—or employees—are most practical.

The nurse who codes the records showing certain illness or defects by flagging them as she goes along is able to make numerous interesting and valuable summaries with a minimum of time and trouble. (See Chapter 14.)

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much public excitement over them, such surveys furnish the best method of dealing with the situation.

Surveys to discover children with emotional and social problems. While this is the type of a survey for which the instructional, supervisory, and administrative staff would carry more responsibility than would the nurse, her participation may be very helpful and certainly the findings as she utilizes them in her study of individual children are most valuable.

In this survey, as in those for many other purposes, there is opportunity for great variation in the plan used. In a school where not much has been done in working with pupils on their social and emotional problems, the first "survey" may consist only of the teacher's listing of the names of her pupils whom she feels show some of the indications of such problems. She may be asked to make this judgment on the basis of a list of such indications that is furnished her. These children then may be observed and interviewed by a psychologist, psychiatrist, or social worker.

When the specialist service available is limited, the teacher may be interviewed by the psychologist, psychiatrist, or social worker and assisted in choosing the pupils she will put on the list.

When enough specialized service is available, the specially trained worker may interview and study the records of each pupil.

Tests which are designed to reveal certain problems may be administered by the teacher to her group, or again if service is sufficient, they may be administered to groups or individuals by the specialist.

Survey of narcotic addicts. In a school without adequate day-by-day health supervision, a special survey may be necessary. Ordinarily, however, these children would have been referred by teacher, nurse, or parent for a physician's examination because of sudden personality or behavior changes. Puncture wounds, sores, or abscesses may be observed, but since these have many other causes, the teacher avoids any statement of suspicion but is particularly careful to ascertain that the referred child actually gets to the nurse or physician.

If a special survey seems required, it should be done as thoroughly as possible, by physicians and with the pupil's clothing removed as for a medical examination. For good public relations and also to salvage some of the considerable expense involved, and to obtain some positive results, the inspection might well include an orthopedic inspection in addition to that required to locate drug users.⁽¹⁵⁾

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*The Nurse's Part in Individual Pupil
Appraisal and Assistance in Follow-through
to Secure Attention to Children's Needs*

For pupils needing school adjustments. Such pupils are discovered as a result of the periodic appraisal, or the continuing supervision of teacher and nurse, or from reports to the school by parents, pupils, or cooperating agencies. Singly and in groups, pupils are found who need special adjustments and individual services which can be supplied to them within the school and by the school staff. Included are such provisions as those for rest periods, between-meal feeding, unusual toilet privileges, corrective exercises, reduced or increased scholastic activities, reduced or increased extra-curricular activities, special seating arrangements, avoidance of stair climbing, or perhaps special textbooks. There is no limit to the variety of individualized arrangements which may be indicated when a school and a community have really accepted the idea that the school is for the pupils, that pupils differ, and that there can be variety, order, and organization without regimentation. Pupils sometimes seem quicker to accept the justice of variations to meet individual needs than do the adults who have already been conditioned to the traditional convention of regimentation in the school and cling to it.

While identification of the individual need of a pupil for a special adjustment of program, activity, or equipment is the first step, it is not enough. Knowing the need does not guarantee that it will be met, even though only a simple change is required. The second step is a decision as to just what the change should be. The third essential is definitely placing on a certain staff member the responsibility of seeing that the plan is put into operation, and, equally important, for either continued supervision or a periodic checking to ensure its proper working. A frequent review of the situation is needed to determine if it is producing the desired results.

A fourth provision is for a rather formal review of all such special arrangements at stated intervals to see if they are still needed. It is not only inefficient and possibly expensive to continue them when they are no longer needed, but their continuance may be harming the child.

In the elementary school. Principal, classroom teacher, physician, and nurse are usually the core of the group which does the planning for school adjustments for elementary pupils. They are supplemented, according to the needs of the individual case, by such staff members as the physical education director, attendance worker, building superintendent, special teachers, and others as indicated. The pupil is seldom included in the conference, and the parent may or may not be needed.

Assignment of responsibility for following through on the plan to a selected staff member is decided by the group or the principal. There may be no choice—it may be a situation such that one person and no other is in a position to see to it. In other instances where there are several possibilities it may be assigned to a staff member for whom it will occasion the least inconvenience, or perhaps to the one with whom the pupil has a particularly good relationship.

It is usually to the same group which created the plan that a periodic review is presented to determine whether it is desirable to continue the arrangements for a longer period.

In the secondary school. In a small high school or even in a large one if there are few pupil personnel workers, the procedure may be that described for the elementary pupils.

More often than not, however, the dean, guidance director, advisor, or health director functions instead of the principal, and a "personal advisor," under that or another title, takes the place of a classroom teacher. The physician and nurse function with them in making the plan. Certain classroom teachers are drawn into the group, perhaps because of their special interest in the pupil being considered, but more often because of the involvement in the pupil's problem of the subjects they teach, or supervision for which they are responsible. The pupil often is brought in at least for the latter part of the conference; the parent less often.

A greater variety of staff members are available to whom responsibility may be assigned for putting the plan into effect and for its continued supervision, than is usual in the elementary situation. Also responsibility for establishing the plan may be assigned to one staff member—perhaps one of the pupil personnel staff—while the continuous supervision is assumed by a home room teacher or the advisor.

Unless participation of other students and staff members is required in carrying out the arrangements, the privacy of the pupil should be respected, and unless he desires to inform others of the matter nothing should be said about it.

Follow-through outside the school. It may be obvious from the first that the needs of the pupils are such that they cannot be met by the school alone. It may become apparent only after the planning group attempts to handle the problem.

The school physician, nurse, or social worker—if there is one on the school staff—may be in charge of planning for follow-through outside of the school more often than the principal who is apt to be the person who initiates the plan-making for school follow-through. While not indicated routinely, there are instances where planning for follow-through outside the school may well begin with a conference similar to that suggested for planning the school follow-through. Especially is this true when adjustments are needed rather than diagnosis or medical, surgical, or dental treatment. Such a conference may in this case go no further than to explore more fully the pupil's needs and may actually be functioning as a continuation

A difficult group is made up of parents who may or may not be financially able to secure needed attention but because of fear, ignorance, religious belief, superstition, or procrastination neither place the child under treatment nor are willing to accept aid. The patience and ingenuity of the nurse are taxed in these cases, and special action may be necessary to safeguard the health and welfare of the child.

City population group	<i>The Frequency of the School-Parent Conference Expressed in Per Cent</i>			
	Regularly	Only for special cases	Seldom	No provision
1	2	3	4	5
	%	%	%	%
United States	43.8	41.1	2.3	12.8
Group I 100,000 and over	67.9	25.0	0.0	7.1
Group II 30,000 to 99,999	59.7	31.8	0.0	8.5
Group III 10,000 to 29,999	46.7	44.0	0.7	8.5
Group IV 2500 to 9999	38.8	42.2	3.4	15.5

A study made of 66,871 high school seniors of whom 8301 were found to have 9636 defects still untreated when they were about to graduate showed that in fewer cases than had been supposed there was a lack of treatment due to inadequate, or delays in, welfare facilities for treatment. In 32 per cent of the untreated defects where treatment had not been obtained the reason had to do with money. In only 163 cases of defects had welfare officials refused help. In 96 instances families had refused such help; in another

to know the real situation in regard of the attitude of pupil and parent toward medical treatment. It goes much deeper than the knowledge a clerk or principal might obtain through a school interview with the pupil and a report through the pupil of his parents' attitude. Such physicians reported less indifference among the parents and more frequent objection on the part of the pupils than did other staff members making the study.

Schools with largest ratio of nurses per pupils have better opportunity to obtain information about their pupils than is possible for schools with less nursing coverage. In high schools with full-time school nurses where the pupils can be closely studied by the school health personnel, the pupils' own objections to seeking treatment for defects were found to be the reason five times more frequently than in schools with minimum nursing service. Further, in schools where there was little or no nursing service, certain reasons for lack of treatment were not discovered at all, such as religious objections, unfavorable previous treatment, and aversion to surgery.⁽⁵⁾

Differences in professional opinion were found to be the cause of lack of treatment in 221 cases; objection to surgery in 135. In 67 cases there was objection on religious grounds; in 39 instances the reason was an unsatisfactory previous treatment of the pupil, a member of the family, or of someone known to them.

In 675 instances or 7 per cent of the total group of defects not treated there had been a failure to convince the parent of the need for treatment. In 77 cases the child's guardianship was ineffective to guide him properly. In the other 19 per cent of the untreated defects, the parents and the pupil seemed to want the treatment and to expect to get it. They simply had not got around to it, sometimes because professional service was difficult to obtain, again because some serious family problem was disrupting the family, or because so much work was needed—in 29 cases complete dentures were required and the amount of time and money required seemed too much.

Necessity for determining actual reason for lack of treatment. Until the real reason for lack of treatment is determined, little progress can be made to remedy the situation. Skill in inter-

When the parent is present at the examination, the parent may be asked to sign the notification at that time. When a home call is made to notify, as is advisable in certain instances, here again the parent may be asked to sign the form before the school visitor leaves. An explanation of the legal reason for this can be used to make the parent realize the importance put upon the matter.

For the notices sent to the parents who are not present at the examination and upon whom a notification call is not made, the classroom or home room teacher is often made responsible for securing the return of the signed notices. In other instances the pupils are instructed to take them to the nurse in her office or to give them to her as she visits the classroom for the purpose. Unless such a visit is made each day (which is apt to be wasteful of nurse and class time) this is not a good plan as the pupil should be allowed to turn it in at the first possible moment.

Occasionally there is an uncooperative parent who refuses to sign the notice. The school is protected, if the nurse and one other person discuss the matter with the parent and are able to affirm that the parent understood the findings and was properly informed. It is such a parent that is most likely to be looking for a chance to "make trouble," and is less likely than others to respond to an invitation to come to the school for a conference. The nurse and classroom teacher make a natural team for a home call on such a case. If the parent does visit the school, the principal and school physician may well make the official notification.

For the many parents who appreciate the school's effort to help them supervise and improve their children's health, the notices are most effective if sent the same day the examination is made. In a school with a permanent staff, an effective way of doing this is to have the physician step into the nearby office of the secretary after each examination and dictate a few supplementary sentences to one or another of various form letters previously worked out for the types of conditions most often encountered.

The secretary writes the letter while the physician is examining the next child. She makes carbon copies, one for the health service file and when indicated one for any particular staff member who

would be concerned. For elementary pupils, the classroom teacher may routinely receive carbons of all letters. The child is given some reassuring statement, and told that since the school knows his parents will be interested, a letter will be mailed that day telling about the examination. A slip on which the parent is to acknowledge the notification is enclosed. In some schools this is in the form of a self-addressed and even stamped postal card. More generally it is suggested that it be returned to the school by the child. The letters from the school to the parent must be sent by mail or delivered by a member of the school staff and not sent by the pupil.

Repeat notices. After the stated time for the acknowledgment has passed, a repeat notice may be used for parents who have not replied. There may be an advantage in having this notice quite formal, while in the original notice there is an advantage in using a tone of informality, friendliness, and individualized attention. One such form is:

REPEAT NOTICE

(Name of School)_____ Date_____

Following the medical inspection of _____, a notification was sent you and you were advised to consult your physician, dentist, or other specialist regarding the need for treatment. A form for your reply was included. We have not received this.

It is the school's responsibility to know that no child's health is being neglected. We are sure your child is not being neglected but must have your statement about it. Will you please inform us of what has been done?

(Signed)_____

Title of School Administrator

The notice is signed by the administrator rather than by the physician or nurse to emphasize the point that it is the school's responsibility to "know" about the children, and that it is not to give them medical follow-up. Signature by the school physician, especially if he is not a full-time school physician and engages in private practice in the community, may cause personal criticism of him by his fellow practitioners.

Tabulation of returned acknowledgments. While this responsibility is too often assigned to the teacher or nurse, it is a clerical job and is more efficiently and economically done by a clerk. It cannot be assigned to student help because of the nature of the information received.

Second step. For some, no next step is necessary because the condition has been taken care of. Another group can be set aside for reconsideration later, for the parent has stated that action is planned and there is no reason to doubt that it will be taken. Certain cases are sorted out for consideration at a conference such as is described earlier in this chapter.

In some instances the replies indicate that the parent has failed to understand what is involved. This may be cleared by a conference with the pupil, an informal note to the parent, or a telephone conversation. A face-to-face conference with the parent may be required, and this may be arranged at the school with nurse, physician, principal, or teacher. A home call may be indicated and made by nurse or teacher. For all cases still uncared for, the second step is assurance that the parent *understands* what it is all about and has a general idea of what is needed.

Third step. This is to find out why the parent is not acting. What he says is the reason, or what the pupil quotes him as saying may or may not be the real reason. Until the school worker learns what this is, any progress is impossible. (See Chapter 16.)

When the family needs financial assistance. The family already on relief offers the least difficulties from a financial point of view provided the condition is sufficiently serious. Since the days of the depression the inclusion of medical care for such families is a well-accepted policy.

Official welfare services. It is, of course, essential to have complete rapport between the school health staff and local welfare workers. The nurse should know these officials personally and consult them about the school children of families under their jurisdiction. It is possible to save a good deal of time and effort if plans and policies are worked out in a conference of school officials and representatives of the welfare office as to the procedures that are

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to be followed in the many types of situations in which the two groups have a mutual concern.

In individual cases it may be that the nurse will have to convince the welfare officer that the relatively small charge for remedial or corrective treatment for a pupil in school may mean saving of larger funds later when an untreated condition may lead to a permanent charge upon the community involving a chronic invalid, a handicapped child, or a maladjusted or delinquent child.

When a family is not "on relief" for food and lodging but is "medically indigent" requiring help in securing necessary medical care, the nurse may find progress a little more difficult, especially in areas where welfare work is not highly organized and the workers are less well trained, or where there are no professional workers and the relief is administered directly by the elected official.

Deciding financial status. If there is a council of social agencies, a social service exchange, or any arrangement for an exchange of information between official and nonofficial agencies, the nurse will keep herself informed of any such services and use the facilities.

If no formal agencies exist in the area for approving cases for financial assistance, and the nurse must assume the responsibility or assist in it, she must be sure of her facts. As a matter of routine she makes a call to the home and secures information regarding family circumstances. This includes such items as number in the family, in the household, ages of the children; number of members working with places of employment; total income of the family; if wage-earning members are not employed, the reason; a statement of any property owned; family illness during the past year; any other significant misfortune the family has had in the past year or two; what help the family has had in the past.

The nurse needs to obtain some but not necessarily complete corroboration of the information. A good source is the family physician. If the family is new in the community (and often it is) a letter to the principal of the school formerly attended may bring helpful information. If there is a religious affiliation some information may be obtained from the clergyman or a church social worker.

The extreme caution which must be used in discussing such families with anyone must be intensified when discussing them with nonprofessional persons. The nurse aims to obtain a maximum amount of information while giving out a minimum. While she will be generous in sharing with teachers information that may enable them to understand their pupils better, she will regard all information relating to private affairs of families as confidential. She will protect child and family from any unnecessary or gossipy discussion of family finances or difficulties. In the home as in the school the child should never be present during the discussion of family difficulties. With some parents as with some teachers, responsibility for preventing this may have to be assumed by the nurse.

Official decision regarding financial responsibility. When it appears to school authorities that official welfare help is indicated but the local welfare officials do not assume responsibility, there are two lines of action possible: (1) an attempt may be made to secure help from unofficial funds, or (2) one may "go over the head" of the disagreeing official. The nurse never proceeds to the second step on her own decision. Full support of the school administrator and in many instances of the board of education is required, and usually the action is taken by some school official other than the nurse. A decision to take such a radical step is seldom warranted unless the case is typical of a group of cases and the action is taken to establish a policy.

Appeal may be made to the state agency responsible for the administration of the public welfare law. Another possibility is to bring the case into children's court or into a court with similar jurisdiction so that the judge may order the needed treatment and specify the source of payment.

Assistance from unofficial sources. For financial borderline cases it is often especially difficult to find means of help in small villages and rural communities because there is no established method for giving it. As the nurse becomes acquainted with private physicians she may find among them individuals willing to take care of certain types of cases without pay or on deferred payment ar-

rangements. Nonprofessional individuals may be discovered who have special concern for children with certain difficulties and can be called upon to help.

When no "agencies" exist. Establishment of a "loan" fund or a "part pay" fund is possible in practically any situation. In some schools these were started during the depression years of the thirties by faculty members putting in a certain per cent of their salaries for a pupil welfare fund. In others they have been started with money raised by a faculty entertainment—a play or an exhibition game between a faculty and a student team, or two faculty teams. Sometimes the pupils raise the money or part of it through entertainments, sales, or work activities.

One of the best methods of administering such a fund is by a community committee (not a school one) setting up the general policies to determine the situations in which help shall be given. A committee or even perhaps a single member of the school staff may be the only ones to know which families are receiving the loans. Success of the plan may rest upon its confidential nature.

Loans may be made on the pupil's own promissory note if he needs immediate care and is expecting to be employed part time or during vacation. Such experience may be used to help the pupil learn to budget for his unusual health expenses and to assume responsibility for his own needs.

When parents fail to meet the child's needs. Under the best of circumstances and no matter how conscientiously she works, the nurse will find some cases which are not put under treatment. However discouraging the situation may seem to be, the case of a school child with a condition that needs treatment is never considered "closed." Action on it may be suspended for a time, but as long as the child remains in the school district and the condition persists the case is regarded as active.

Experience shows that no situation is hopeless. There may be nothing more that the nurse or school can do at the moment, but with the passage of time circumstances may change. There may be a change of attitude in the family; guardianship of the child may pass to a person with different ideas; or the local situation may

change so that new possibilities open up. The child may change his own attitude because he desires to participate in competitive athletics, or obtain an employment certificate or a driver's license.

Each time the defect is noted as the physician examines the child a notice may be sent to the parent even though the cause of non-treatment is known and there is little expectation of action.

Care should be taken that repeat notices are not sent to static or unremediable cases when it is known that the parent is keeping the child under professional supervision and that recommendations are being followed. The real service of the nurse and the school in such cases may be to help the child and his family make adjustments in their attitudes toward the condition and toward each other that will as far as possible normalize their living. (See Chapter 12.)

Use of exclusion to force treatment. The use of the terms "exemption" and "exclusion" may be confusing. The nurse should inform herself of their exact meanings in the particular state in which she is working. Usually exemption refers to a more formal procedure and one designed to remove the pupil from the school register and attendance record. A child who is to be exempted because his physical or mental condition is such that he will not profit from attendance is usually examined by a stated number of physicians, or perhaps by a physician and a psychologist in the case of a mental retardation. A minimum and a maximum are usually stated as to the length of time the exemption can hold, often it is for not less than six months or more than one year. Generally special forms for the purpose are provided by the state agency responsible.

Removing the child from school attendance does not remove from school authorities responsibility for providing as much education as the child can profit by, through use of a home teacher. The school also has responsibility, if the condition of the child warrants it, of referring him to proper health or welfare agencies for special care. Certain cases will require follow-up, after exemption; for example, a pregnant unmarried girl of school age, or a child admitted to an institution if there is severe mental retardation, blindness, or severe epilepsy which proves unresponsive to treatment.

"Exclusion" as viewed from a medical angle is of a more temporary

nature. The period is shorter and the process less formal. The principal (usually acting on the advice of a physician or of the nurse) may exclude a pupil from school attendance when the condition is a menace to the health or safety of himself or others. The nurse never excludes without authorization.

The pupil returns to school upon recovery from the condition which caused the exclusion. There may be more formality involved in his return than in the exclusion, depending upon the condition, state laws, and local regulations. Examination by a physician, inspection by the nurse, or a note from the parent may satisfy the requirement.

Close supervision may be required in some cases to prevent malingering. School authorities may at any time during the exclusion require a statement from an attending physician, or submission to examination by the school physician, or to inspection by the nurse, to determine that the child is or is not in condition to return to school. Failure on the part of the parent to return the pupil to school because of a lack of treatment may be interpreted as legal detention in many states when the condition is such that it might have been remedied by use of reasonable and possible measures. In this way pressure may be used through the attendance laws to stimulate the parent to provide treatment.

Exclusion is used when there is a communicable disease—both reportable and unreportable. It may also be used for chronic and unjustifiable uncleanness and in extreme cases of other kinds where parents refuse to provide treatment for a remediable condition when they are able to do so.

Exclusions should be short even when it is anticipated a re-exclusion will be necessary. Supervision is essential, especially in instances of unreportable communicable conditions such as pediculosis, impetigo, scabies, conjunctivitis, and similar conditions.

In isolated cases, and *only* after all educational means have been used with no results, exclusion may be used to force treatment of a defect or correction of a communicable or unhygienic condition. Before a nurse recommends to her school authorities that attendance procedures be begun to secure treatment, she must be sure that it

can be shown that nonattendance has interfered with instruction or satisfactory progress in school. There must be evidence that the parent was notified of the condition; this may be the parent's signature on the notice acknowledging the message or a witness of a discussion of the matter with the parent. There should be a written account, as part of the pupil's record, of conferences with the parents at which necessary information and explanations have been given the parent so there can be no doubt that there is understanding of the condition and of the necessity for treatment. The conferences may have been home calls or conferences at the school or both and they may have been with the nurse, school physician, classroom teacher, principal, or other staff member.

In many apparently hopeless cases this intensive preparation for making a court case succeeds in securing action from the parent with no further procedure.

When it does not, however, the next step is for the nurse or another worker to have an informal conference with the individual who is later to hold the hearing on the illegal absence of the pupil. This may be the superintendent of schools, the attendance director, the judge of children's court, court of special session, justice's court, or other authorized person. This individual must be shown that every effort has been made to educate the parents to see the necessity for treatment and to assist them in planning to obtain it. His approval of the plan to go on with the case is secured.

The principal or teacher in charge then excludes the child from school with a definite written statement to the parents restating and explaining again the reason for exclusion (that the child is not in condition to profit by instruction, that his presence is a hazard to others, or other). Procedures desirable for the parents to take are again enumerated.

After a certain length of time, depending upon the care needed and the circumstances, if there has still been no attempt to obtain treatment, the case is referred to the attendance officer as one of illegal absence and a hearing is arranged.

The official holding the hearing determines the next procedure. He may order the treatment. Perhaps he rules where the responsi-

nature. The period is shorter and the process less formal. The principal (usually acting on the advice of a physician or of the nurse) may exclude a pupil from school attendance when the condition is a menace to the health or safety of himself or others. The nurse never excludes without authorization.

The pupil returns to school upon recovery from the condition which caused the exclusion. There may be more formality involved in his return than in the exclusion, depending upon the condition, state laws, and local regulations. Examination by a physician, inspection by the nurse, or a note from the parent may satisfy the requirement.

Close supervision may be required in some cases to prevent malingering. School authorities may at any time during the exclusion require a statement from an attending physician, or submission to examination by the school physician, or to inspection by the nurse, to determine that the child is or is not in condition to return to school. Failure on the part of the parent to return the pupil to school because of a lack of treatment may be interpreted as legal detention in many states when the condition is such that it might have been remedied by use of reasonable and possible measures. In this way pressure may be used through the attendance laws to stimulate the parent to provide treatment.

Exclusion is used when there is a communicable disease—both reportable and unreportable. It may also be used for chronic and unjustifiable uncleanness and in extreme cases of other kinds where parents refuse to provide treatment for a remediable condition when they are able to do so.

Exclusions should be short even when it is anticipated a re-exclusion will be necessary. Supervision is essential, especially in instances of unreportable communicable conditions such as pediculosis, impetigo, scabies, conjunctivitis, and similar conditions.

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In some advanced communities of which there are only a few it can be used to protect his social and emotional needs as well. Use of pressure of any kind is distasteful, but may be the lesser of two evils if compared with neglect of a vital need of the child. The nurse must be careful to discriminate between her own and the community's interpretation of such a term as "vital need," especially if her own cultural pattern is in contrast to that of the community in which she is working.

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bility for payment is to be placed—on parents, welfare officer, or other.

Guardianship. In extreme cases a court may remove guardianship, appoint a new guardian who may order the necessary treatment, and when this has been obtained guardianship may be restored to the parent. Unfortunately not all communities offer the services of a juvenile court to their children. In those that do, the courts operate under laws which vary from state to state.⁽⁴⁾ One of the most notable powers of a juvenile court and one which its best judges are most wary in using is to order the disposition of the child without the consent of its parents.⁽⁵⁾ Laws regarding guardianship vary greatly throughout the different states. There is general acceptance of the provision, however, that every child has (or should have) a guardian whose responsibility it is to make decisions regarding his physical care. There is no state in which the school is regarded as the child's guardian even though it may have to take temporary responsibility in an emergency, when parent or family physician cannot be reached, for making a decision if immediate action is necessary.⁽⁶⁾ In such a circumstance the school is regarded as acting *in loco parentis* rather than as guardian. Every effort is made to reduce the number of such occasions by including on the pupil's health record directions for reaching the parents and designation by them of relatives or friends who may be consulted in their place when they are inaccessible and an emergency arises.

Before resorting to removal of guardianship the judge may impose a fine on the parent for the illegal absence, and then suspend sentence on promise or proof that treatment will be provided. When the case is in the justice's court this is the procedure indicated.

There are occasional families where it is known by welfare or law enforcement officials that preschool children are not being provided for satisfactorily, but it may be difficult, until the children come under the mandatory school attendance law, to secure evidence satisfactory for legal action in order to protect the children.⁽⁷⁾

The mandatory school attendance law may be the best, and for some unfortunate children the only, friend able to protect a certain child from future illiteracy or present neglect of his physical needs.

includes, of course, learning to get along with people and to develop self-control and, to whatever degree he can, to earn his own living.

Evidence continues to accumulate proving that psychological damage from the attitudes of others toward him and overprotection of him is often a more potent factor in a handicapped child's lack of success in later life than is the original limitation. Of course, emotional difficulties occur when too much is expected of a child, resulting in his feeling of failure. Overprotection is the great danger, with the exception of the mentally retarded and the hard of hearing. Probably they are exceptions because their handicaps often are not physically obvious. Individuals who have had rheumatic fever or epilepsy in childhood furnish tragic instances of damage from overprotection. One phase, the too great degree of inactivity, causes not only definite physical damage, but psychological harm.

Activity limitation in school life seems in many communities to be increasing rather than lessening. This is due to the growing personal vulnerability of school board members and teachers to law suits when pupils injure themselves in schools or on playgrounds. Recognition of such liability has been heightened by large judgments given by sentimental juries, the members of whom seem unaware of the very real damage, which will follow to all children, as an indirect result of such awards. In self-protection, schools have been forced to develop policies, placing blanket restrictions on whole groups of pupils, which are disastrous to the majority of them. Organizations of parents may well seek the cooperation of organizations such as those of school administrators, boards of education, teachers, physicians, nurses, and of other groups interested in positive measures for the protection of the best interests of all children, to work for remedial legislation where these conditions exist.

Pending such action, the best results for each child, with the least financial hazard for school system and teacher, can be obtained when parent, family physician, school physician, and other representatives of the school meet in conference to consider, first, what activities may be allowed to the child and later those in which he must be restricted. Preceding such consideration and as a basis for

The Nurse's Part in Pupil Personnel Services for Pupils with Special Difficulties

The nurse's point of view toward these children. The child with a special health problem has two peculiar areas of need in which the nurse has special opportunity because of her professional knowledge and her position in the home and school.

One includes the problems which relate to his special needs—for the best diagnosis available, for excellent and continuous treatment, and for expert consultant service on educational plans geared to specialized vocational guidance. This should be sought very early so that his education will be tailored not only to meet his present-day needs and capacities but to furnish the correct background for his eventual vocational training.

The second, and if anything, the more important area of her special concern for him is to see that he is allowed to lead as nearly a normal life as can possibly be arranged and to ensure that such arrangements are made for him in a way that his similarities to other children are emphasized, rather than his differences. Her objective and that of the school for this child, as for every child, are to do or to help get done all that is needed and possible, to help him to be and to grow into a person who gets happiness and satisfaction out of life, now while he is a child, and later as an adult. This

arithmetic and the teacher who can give him extra help, between the physical education teacher and the child with intensive interest in sports or the child who, because he is physically below par, needs his teacher's special interest and help in practicing the art of living.

She can help him feel this similarity of relationship if she begins each discussion with him by talking first about matters other than those related to his special disability. She may need to help others of the school personnel learn to avoid the easy practice of using problems connected with his ailment to make conversation in casual encounters with him. Since this is the first thing that comes to mind, it does require an effort to avoid it.

The nurse will endeavor to have this child regard her as a person who knows enough about him so that he can obtain help from her when it is needed. He learns that she is unusually interested in him and therefore likes to have him come in and talk over his new experiences with her even when he feels no need of help. Most of all, perhaps she wishes him to consider her a resource person who can give him help—or help him find out how he can obtain assistance he needs—to enable him to solve his own problems, but never to consider that the nurse will solve his problems for him or make his decisions for him.

She can build up the idea of a two-way relationship with him by letting him realize that she considers he has information which might help her in her work with other pupils. She may ask him if he can help allay the fears of another child who is facing hospital experience for the first time, or who must learn to use crutches because of a temporary injury, or who must remain in bed for a long convalescence. Even if he feels he cannot do this, the fact that she has considered it a possibility may build up his opinion of himself and prepare him for such a service later.

Nurse and parent. Another valuable service the school nurse can give the child with serious limitations is helping his parents to anticipate, face, and adjust to the physical, social, and emotional problems the child will meet as he attends school and as he grows up. To the parent as well as to the child, she first emphasizes similarities of these problems to those which all parents have with all

the decisions, there must have been secured the best and most complete diagnosis and prognosis obtainable.

This conference may reveal that the parent and perhaps the teacher concerned are in need of guidance from a psychiatrist or a psychiatric social worker to overcome fear or an overly protective attitude and to face the value of a calculated risk, before a plan can be agreed upon. No greater help can be given a child than to discover such a situation and remedy it.

If a handicapped child has any secondary defects, the nurse puts attention to these high on her list of priorities, for defects cause other defects and this child already has as much as he should be asked to carry. More serious to him than to other children are bad tonsils, poor nutrition, poor posture, indications of possible need for glasses or dental care, and obesity. It is especially important that any deformity, even one for which correction would have only a cosmetic value, be taken care of. His need for his maximum physical energy, for a sense of well-being, of freedom from infection and from anything that will increase his self-consciousness is greater than that of the child for whom the one defect is his only disadvantage.

If unattractive mannerisms develop, the nurse seeks immediately to discover the tensions causing them so that she can work with his parents, teachers, or associates toward the elimination of their causes.

In a school where testing services to determine academic aptitude, mental age, special aptitudes, and vocational possibilities are limited, the nurse will recognize the special need of these pupils for such tests, so that parents and teachers may be aware of their potentialities as well as have respect for their limitations.

The nurse's own relationship to the child. First, in her own thinking, and then in the thinking of the child and his classmates, the nurse must establish the idea that her relationship to him is not emotionally different from that she has with every child in school. The difference, if any, lies in the depth of the association. This is similar to that which may develop between the art teacher and the child with artistic skills, between the child who is poor in

confidence in them. By answering even the most difficult questions of parents or child frankly but softening the answers by encouraging alternatives whenever possible, and by emphasizing the positive rather than negative factors, she sets an example the parents may follow.

Because she has knowledge of community, state, and national resources of publicly supported and of voluntary agencies, which can help parents in meeting some of the special needs of handicapped children, the nurse in bringing parents information about these may also have opportunity to help them accept the idea that these children are entitled to more help from the community than are other children. The majority of them are found in families of moderate means because there are more such families than families of the very wealthy and the very poor. Since invariably in the case of the child with a deformity some, if not all, of the usual expenses of raising children are increased (medical care, special foods and medicines, special devices, special clothing, additional transportation, and special education), the family may be forced to choose between three possible decisions. Shall money be spent on this child which will deprive other members of the family of essential things? A second might be: Shall full advantage of diagnostic services, treatment, or special education from which the child might profit be withheld from him? Must the family accept assistance in obtaining some or all of these?

When indicated, the nurse may help the family accept the third course of action by pointing out that as far as education is concerned, few parents today pay for their children's education individually; that it is now a generally accepted concept that education of all children is a public responsibility and for the individual child education must be the kind which meets his individual needs. However, before special education can be ordered, or even planned, the best diagnosis and prognosis possible must have been obtained. Also the education authorities must have evidence that the child has received any treatment that might remove or lessen his disabilities. It is unfair to the child and uneconomic for the school system to provide special education if the condition requiring it

children, rather than the special ones. This child, like all others, must get satisfaction through a sense of accomplishment. What achievements within his power may mean the most to him? What recognitions of progress can he be given to encourage his continuance of effort?

By furnishing reliable scientific information as to his difficulty and assisting parents in their study of its causes, the nurse helps parents find concrete answers to these questions.

Lectures, study classes, and group discussions designed to help all parents to learn how they can give their children a sense of security and a feeling of belonging to the family will help these parents in their effort to obtain the same things for their children. However, to give the child opportunity to contribute to family life and to assume responsibilities in the family often requires additional knowledge.

As the parents learn to help their child obtain a real satisfaction from life, the parents' own fears, unhappiness, and perhaps even self-blame are reduced. As they are able to work toward lessening the restricting effects of the child's handicap, the parents' frustrations, because they can't remove it, are somewhat relieved.

On all parents the nurse may exert a stabilizing influence in their attitude toward medical care. With some, she may need to stimulate the seeking of more and better medical and surgical care. With others her influence must be directed toward their persistence in following directions of a reputable physician or clinic rather than changing from one to another. Always the nurse has a responsibility to guard parents from the "quacks" who are ever ready to prey upon the hopeless or difficult cases.

The nurse will discuss with parents the value of broadening the child's social circle but she will not stop there. She will help plan occasions in which as many of the family as possible participate in his activities. She will help them develop projects in which the child can participate with other children.

By her own example in always dealing truthfully with the parents and the child, she will demonstrate the value of such truthfulness in the parents' efforts to build up the child's feeling of complete

Special classes and special schools. Special skills and special devices have been developed for more effective teaching of handicapped children. Some of these are suitable for use in a general classroom. Their advantages can be brought to the child who spends most of his time in a general classroom but who receives special instruction during certain periods of the day or week.

In other instances, it is to the advantage of the child to join a special classroom group. When such a class can be located in a "regular" school building so that the pupils will associate with unhandicapped children except when actually in the classroom, it is considered more desirable than to place the class in a building made up entirely of special groups. There are circumstances, however, when the special school or even the residential school is indicated. In these schools expert services in teaching and treatment are possible to a greater extent than with smaller groups of children. Also the strain under which the child lives when he is competing with unhandicapped children is reduced, both because of the protections and adjustments arranged for the group and because all his associates are handicapped also.

Development of proper attitudes in fellow pupils. Participation of the child's own group in planning the special arrangements involved, rather than a passive reception by the group of assignments made to them by the teacher, may be valuable education for future citizen responsibilities. It may develop in the group a positive attitude of personal concern for those who need more than ordinary consideration from others, which will carry over into adult life. Certainly, it helps establish a pleasanter atmosphere. From a practical point of view there is the advantage that the children are often quicker than the teacher or nurse to recognize contributions the child may make to their group activities in spite of his limitations. The pride of the group in seeing his successful carrying out of their suggestions is augmented by their sense of participation in having helped make arrangements. Their pride increases his self-respect. The natural curiosity of children concerning anyone who is different, utilized in this way, is one step in developing an adult public in the next generation which will have a more constructive

could be removed or reduced. Parents are helped to appreciate that the public as well as parents has a stake in the maturing of such a child into a well-adjusted self-supporting adult. The nurse may point out that ever-increasing numbers of people participate in raising special funds such as those for the care of infantile paralysis cases, for children with cerebral palsy, for national and state societies for the prevention of blindness, for the hard of hearing, and for the American Red Cross. As a result, when disaster strikes, families previously self-supporting find no stigma attached to accepting their help. This has long been accepted in case of the Red Cross. More and more in polio, patients requiring long-continued care feel no humiliation in accepting assistance.

Regardless of the amount of help they accept in the way of scientific and professional information, medical or surgical services, or education, parents still carry the greatest responsibility for providing fundamental essentials no one else can supply to the child—the love of his family, his sense of belonging to a family (even, or perhaps we should say, especially, if he must go away to school), and the stimulation he needs for enthusiastic and continued effort to overcome his difficulties. Loved ones who appreciate and rejoice with him over every accomplishment, no matter how small, give him an impetus for continued effort.

Nurse, child, and administrative arrangements. The nurse, the child, and his teacher work together to determine what special arrangements and facilities may be needed to allow him to take part in the community life of the school with safety and with a minimum of embarrassment and a maximum of satisfaction. Even if it proves more expensive to allow him to stay in the regular classroom than to relegate him to a special class, the nurse must be able to present the advantages of the arrangement so effectively that this decision is reached.

Special provisions may need to be made for fire drills, use of toilets, bus transportation, and in some instances for getting in and out of the building and up and down stairs. It may be found that special textbooks and furniture may be easier to provide than it is to arrange special schedules and rest periods.

Use of glasses (Please check): None () For close work only ()
 Not during strenuous physical activity () Always ()
 Until_____

Recommendations for educational adjustment: Remain in regular class () Place in sight-saving class () Limit close work ()
 Supply clear type textbooks () Arrange for orthoptic training () Limit physical activity ()

Are there any further recommendations for follow-up or modification of school program?_____

Are there any symptoms for which to watch?_____

When do you wish pupil to return to you for recheck?_____

Are any other examinations or treatments indicated? (Specify)_____

Name of refractonist_____

Address_____ Date_____

The nurse informs each teacher of the pupils in her group who need special supervision. She asks the teacher to make periodic checks to see that those who should be wearing glasses are doing so. The nurse supplements this by occasional checks of her own. She pays particular attention to care and cleanliness of lenses and proper condition on fitting of the frames, as children sometimes outgrow frames more quickly than lenses.

A few days after a pupil returns to school with newly fitted glasses, when he has had time to become accustomed to the new lenses, the nurse records his Snellen reading with and without them. These data are used for guidance in determining later whether he needs to be referred for a recheck earlier than the date expected.

If after all possible treatment and correction, vision in the better eye is still 20/70 or worse, or if because the condition is progressive special education is recommended, the nurse takes up with school administrator and later with parents the matter of special education for the child. In some states it is required that such pupils be reported immediately by the school to a specified state agency which may be in the state department of education, health or social welfare, or perhaps to an independent agency such as a state commission for the blind. In some states not only the 20/70 or worse pupils who are considered candidates for admission to special classes must be reported, but also those with vision of 20/50 in the better eye.

attitude toward people with handicaps than unfortunately is now generally the case. When the other children focus their attention on how they themselves can help the unusual child improve and in noticing and giving recognition to even slight improvement, they share his satisfaction and, by doing so, increase it.

Although children are born with no natural aversion toward a person with variations from the normal, they quickly absorb the attitudes of those around them, whether they are expressed openly or indirectly. The nurses and teachers can therefore do more by their own attitudes toward the child than by "preaching" to his classmates.

Visually handicapped. Adequate protection of this group of pupils rests upon good teamwork between the pupil, his teacher, his parents, his family physician and eye specialist, and the school health service.

His eye specialist is entitled to prompt information concerning any new or exaggerated symptoms. He is entitled to assistance from the school in getting the pupil back for re-examination at desired intervals even when no change in symptoms appears. He needs help in seeing that the pupil uses his glasses when and as he should and that frames are kept properly fitted.

The health service needs detailed recommendations from the specialist as to wearing of glasses, modification of study and activity programs, and date for return appointment. In serious cases, if proper education guidance is to be given, prognosis is very important. (See page 232.)

An effective technique has been developed in some schools for this exchange of information by use of a two-part blank which is sent by the school with the child when he is referred for an eye examination. The first part is filled out by the school and includes the pupil's name and the school address to which the ophthalmologist or optometrist is asked to return the blank. The school includes a history of the eye condition, symptoms of eyestrain, and any other pertinent information about the child.

The second section which is to be filled out by the refractionist includes:

it is for the parents of such children, the group for whom it was especially prepared.

Information derived from special studies on lighting is obtainable from the General Electric Research Laboratory, Nela Park, Ohio, and belongs in the faculty library. From the National Society for the Prevention of Blindness, many helpful materials on this subject are also available, including those on classroom lighting, office lighting, and on visual problems in the classroom. In the crowded conditions because of lack of necessary school construction, nurses, teachers, clerks, and principals are often found doing desk work under very poor conditions.

For schools with special classes for the visually handicapped, or for a school lacking such a class but with a child in a regular classroom who needs the special provisions, a subscription to the society's periodical *Sight-Saving Review* is a "must," together with the numerous articles on the subject listed in the society's catalogue.

When the nurse has used all local and state resources of which she has or can obtain knowledge, and still the child's needs for conservation of what vision he has or for education adapted to his special limitations are not being met, she may write to the society to see if there is some possibility of help which has been overlooked. While the society does not give case work or individual nursing care to individuals, it does have an over-all knowledge of resources, official and voluntary, and may be able to put the nurse in contact with a local or state agency she has overlooked.

In too many parts of the country there is still a sad dearth of local facilities to care for children with minor vision defects. And there is a failure on the part of some local welfare agencies to accept responsibility for professional eye examinations and glasses when necessary for children from families not on relief but which should be classified as medically indigent and given such assistance. However, it is seldom indeed that the extreme case cannot be taken care of. States, in general, early accepted responsibility for the blind, so it has been easier to expand the program beyond that group and secure legislation and funds for the care of the next group—that of the partially sighted. Also, state funds and facilities have been aug-

One reason for this is to ensure special attention for marginal cases. A second value of such reporting is that it enables the responsible agency to know that school systems are testing and reporting. Only in the smallest of schools would there be no child with corrected vision as low as 20/50.

There will usually be available from one or more state agencies material on lighting, testing, and conservation of vision helpful to nurse, teacher, and parent in protecting the vision of all children. In addition the nurse should feel responsible for obtaining more specialized published information relating to adjustment of the pupil with defective vision to working in the regular classroom, and methods of securing special education for pupils requiring it. If not obtainable through a state agency, the nurse may write to the National Society for the Prevention of Blindness for its publication list.

Among the books and pamphlets published by or for this society which should be in any faculty library are:

Hathaway, Winifred. *Education and Health of the Partially Seeing Child*, rev. ed. Columbia University Press, New York, 1948. ill.

———: *Easy on the Eyes*. The John C. Winston Co., Philadelphia, 1947. 88 pp., ill.

National Society for the Prevention of Blindness: *Eye Health—A Teaching Handbook for Nurses*, 3rd ed., 1947. 108 pp., ill. \$ 60. (Though addressed to nurses, it is especially valuable for teachers.)

Phelan, Anette M.: "Teacher Practices and Conditions Affecting the Eye Health of School Children," reprinted with revisions from *School Management*, January, 1938. 12 pp. \$.05.

For both faculty use and for the nurse to use with parents this organization has available numerous other inexpensive pamphlets on such subjects as strabismus, nutrition and vision, eye exercises, cataract, contact lenses, the effects on children's eyes of such things as television and fluorescent lighting, typography and readability, legibility in comic books, and on the relation of reading difficulties to eye defects.

For faculty use and for high school health classes' reference, *The Handicapped Child* by Stern and Castendyck is as valuable as

In the preschool age group, it is the children who are not blind but who have serious defects of vision who are perhaps the most neglected of all handicapped children, with the possible exception of those deaf or hard of hearing. In the first place, they may go unrecognized. Then when recognized, some parents think the child may outgrow the difficulty. In another instance, the defect may be suspected to exist; the parent may seek professional advice and be incorrectly advised to "wait 'till he is older."

Every nurse, and especially the "school" nurse (even considering her from the narrowest point of view), has an urgent concern in getting these children to the best of professional attention. Whenever she learns of a child with an eye injury, or evidences of strabismus, she immediately refers him to his physician and an appropriate agency. Or if there is none in the community, she puts him on her list for her own immediate follow-up. In either case, waiting to give him attention until he enters school may be too late for him to be helped.

Whenever one eye has been injured, the most expert advice must be obtained in order to ensure care not only for the injured eye but to do everything possible to save the uninjured eye. Neither external appearance nor the amount of pain are necessarily in proportion to the amount of injury done to the affected eye, and a sympathetic ophthalmia may develop from the injury to destroy the uninjured eye. This may happen long after the injury had apparently healed. Therefore, even if the nurse does not learn of such an accident until long after it has occurred, she nevertheless puts it on her list to secure immediate professional attention.

Undoubtedly one reason why strabismus is not regarded more seriously in young children is because even in infants with normal vision, strabismus seems to be present. Some develop the ability for the two eyes to see together as early as at two months. A child with normal vision and eye muscles will develop this ability at least by six months, and immediate concern should be felt when he does not. Since glasses may be given as early as at 12 or 18 months, and even surgery as early as 18 months, immediate examination by an ophthalmologist is vital.

mented by the social security program for crippled children through the United States Children's Bureau. Paralleling official concern is the assumption by many voluntary groups of some responsibility for the blind, for children, or for helping families unable to meet their children's needs. As a last resort, when the nurse has assured herself there is no existing agency with the responsibility or the desire to help such a child, she may seek to interest an individual in the case, or to stimulate organization of a group in the community to assist with such problems. The nurse does not "close" a case of this kind as the child's need will continue until it is met, and the nurse will continue to work on it. If she leaves the position before she has secured the action that is needed, she will leave a detailed "progress report" so that the next nurse may continue from the point where the previous one left off.

Eye defects in preschool children. Community programs for health supervision of infants and those for school age children are usually better developed than those for the children in the preschool group. Blind children are usually recognized early and, if reported to the proper agency, in most states will receive some supervision through the preschool period. Whenever the nurse learns of such a child, she will check to discover if supervision is being given, and if not, she will try to bring it about, since the parents are in need of the guidance and encouragement which a social worker or teacher specifically trained can give. When such a worker is not available locally, a state agency will often furnish the service. In the rare instance when no such service is obtainable, the nurse herself will do as much as she can in helping the family to adjust to the child's handicap, to give him the day-by-day training which he needs as a little child, and to plan for his formal education. The nurse who obtains the specialized worker's service for the child is doing more for him and his family than does the nurse who attempts to carry such responsibility herself. In the latter case, she will not only recommend to the family study of Stern and Castendyck's *The Handicapped Child* and similar publications, but she will herself study them intensively so that she can help the parents carry out the plans suggested.

with other handicapped children. There is greater variation in the provisions schools make for finding and providing for children with hearing disabilities than for children with most other disabilities. The states differ greatly as to legal provisions—regarding responsibilities placed upon education authorities to carry on testing programs; regarding those placed upon health or educational authorities to secure or provide the specialized examinations necessary for establishing the diagnosis, prognosis, and degree of hearing loss (all of which must precede any plan for special education); regarding responsibility for treatment when parents are unable to secure it; and finally in provisions for special education in lip reading for those found to need it.

Further inequalities occur as some communities have the advantage of a local otologist and others do not. Even where such professional service is locally available, there may be a variation in regard to clinic service available to children whose families are unable to finance care.

In one community there may be a group of interested citizens concerned with obtaining the best possible service and education for hard of hearing children, and well informed concerning the newest developments of possibilities in the area. In another community there may be a widespread pessimistic belief, in the minds of the public in general and of school board members, and unfortunately even in the minds of some physicians and school administrators, that even if these children are to be found "there is not much which can be done for them."

With the best of state laws, and requirements for modern testing equipment and proper testing procedures, it is possible to observe great variation in the degree of success attained in carrying the program through to the desired culmination—where every child found with a hearing defect secures optimum physical treatment, use of a hearing aid if indicated, proper educational adjustment including, when necessary, lip reading and speech instruction.

The nurse may have used all local and state resources of which she has knowledge, and there still may be children on her list whose needs for diagnosis, treatment, or special education have not

In working with parents of such children, the nurse will avoid making guesses as to the cause of the condition, the type of treatment that will be used, or the results that may be expected. The causes are many, as are the ages at which a new strabismus may develop. The types of treatment are varied and include glasses, surgery, wearing of a patch, and exercises. What may help one child may be impossible to use with another; sometimes a combination of many methods is indicated. The nurse does emphasize to the parent that treatment is needed for all such children; that improvement is possible for all, that correction is possible for many if treatment is begun early enough; that there may be good vision in each eye now, but that if they are not treated early so both eyes are used in the first six to eight years of his life, they will not improve later—hence the urgent need for immediate attention. She is careful to avoid encouraging the parent to think that wearing glasses now will ensure he will not have to later, or that surgery will be unnecessary, or that orthoptics alone may be sufficient.

The nurse emphasizes the damage that may be done to the child's personality through delay. There is an advantage if the nurse has had enough opportunity to observe the child so that she can include in the summary of potential happenings something which has already occurred in this child, allowing the mother to make the application herself. He may be withdrawn because of his sensitivity to comments on his appearance, or, for the same reason, he may be overly aggressive.

Health records for visually handicapped preschool children. For all children it is important to have the health history go back as far as possible. There is special need for the children of this group to have a history that covers all of their infant and preschool development. Detailed records of their visual progress and treatment in these years, and in their school years as well, will be more effectively made if special blanks are used to supplement the general health records kept for all children. (See Chapter 12.)

Deaf and hard of hearing. Health supervision of these children includes all that outlined in previous chapters and in addition may require attention to problems going beyond those found in dealing

schools, and even the names of individual teachers who might happen to be available in a community without special schools or classes.

In a community where there is no local otologist and which lacks such supplementary services as are sometimes supplied by a state traveling clinic, the nurse may attempt to interest the administrator in securing from the board of education funds to pay an otologist to come to the community for a day's service periodically or for travel expenses for parents as well as children if the nearest otologist is at some distance. If it is not permissible to use school money for supplying these specialists' examinations as part of the school health service, there may be a possibility of developing the service through the health department or department of social welfare. These failing, an attempt may be made to interest a voluntary agency, such as a crippled children's society, Salvation Army, council of social agencies, or possibly a social group such as a men's or women's service club, a civic or church group, or (and this happens quite often) a parent-teacher group.

The school nurse is apt to have responsibility for continuous health supervision for hard of hearing children more often than for deaf ones. The need of the latter for special instruction is much more acute and is likely to be recognized more readily by school administrators and parents alike, and provisions are made for their entrance into residential schools. Also, of course, there are many less wholly deaf children.

There are still no country-wide statistics on the actual number of school children with impaired hearing nor on the prevalence of the various degrees of hearing loss, but extensive studies indicate a prevalence of 4 or 5 per cent of school age children with hearing losses. It is certain that there are many in every school of any size, some of them recognized as such and others more unfortunate in that they go unrecognized.

The nurse who serves a school with special classes for the deaf will find it advisable to take some of the special courses offered in this field, as there is much highly specialized information needed by one who is to work closely with deaf children and their parents.

been met. There are national agencies to which she may write for guidance as to the possible next steps she may take.

One is the American Hearing Society, 817 Fourteenth Street, N.W., Washington, D.C., which has long given leadership in the development of hearing conservation programs in this country. Special information on problems relating to audiometric testing, educational follow-up, and vocational guidance is given by this national organization on request, as well as a vast amount of printed general information in this field. Its periodical, *Hearing News*, belongs in a faculty library as a reference for nurses, teachers, administrators, health classes, and parents of hard of hearing children. Its publications' list shows pamphlets and reprints of special value for each of these groups.

The nurse may also obtain from this organization a list of its many local chapters which offer varying services according to their abilities. Some have employment bureaus and educational programs. Most of them arrange for instruction and practice in lip reading. Some offer advice on reliable hearing aids, give scientific hearing tests with an opportunity to try out various hearing aids, or maintain a meeting room equipped with group hearing aids. Even though there may be no local hearing society or league for the hard of hearing in her own locality, the nurse who lacks experience in this field will find it well worth her while to make an appointment to visit the nearest one. A conference with its officers will add greatly to her understanding of the many possibilities in the hearing field.

Another national source of authentic information is the Volta Bureau, 1537 Thirty-fifth Street, N.W., Washington, D.C. This was founded by Alexander Graham Bell in 1887, and its aim is service to individuals through education and rehabilitation. Its magazine *The Volta Review* is also valuable in the school library for its current information on hearing questions, for teachers, nurse, pupils, and parents. Nurses may write for special information on individual cases (and encourage parents and teachers to do the same) on any problems pertaining to education or training, such as lip reading, speech correction, hearing aids, auditory training, and special

brother or sister can perhaps be assisted to give the child some tutorial assistance in subjects that prove especially difficult for him to follow in class. The school authorities may provide for such assistance. The nurse can reinforce the teacher's presentation of the need for help to the child.

The nurse will probably give the teacher the same sort of information she gives the parents, about standing where the light is on her face as she talks to the child, choice of the child's position in the room, and encouraging others to give the child consideration when they are speaking to the group in the classroom.

Daily follow-up in the communicable disease program affords the nurse an opportunity to prevent many ear complications. Through readmission inspections and home calls she can recommend early medical attention in cases where there are symptoms of earache, ear infection, difficulty in hearing, or where the pupil complains of noises in his ears. These complications often follow measles, mumps, tonsillitis, scarlet fever, streptococcal infections of the throat, and head colds.

When the pupil returns to school following any of these illnesses, the nurse questions him regarding any possible symptoms of ear complications. When they exist she refers the pupil to his family physician and in cases where medical advice is delayed, she interviews the parent urging prompt medical attention for the existing condition.

Since swimming is so often contraindicated in treatment of ear conditions, a child under such treatment is required to present a statement of special permission from his otologist (personal or clinic) before using school swimming facilities.

A careful check of hearing is made on all pupils returning to school following a brain concussion, a fracture of the skull, or an ear injury. Postmeningitis cases are also checked carefully at frequent intervals to determine hearing acuity. (See Chapter 13.)

As soon as a pupil becomes of work age, he becomes eligible for service from the state rehabilitation service, authorized by state and federal laws.⁽¹⁾ In building up information on the possibilities of such help for the pupils, the nurse also learns resources available

If she is unable to arrange this, she can partially compensate for the lack by obtaining and studying the special literature available from the sources previously mentioned. She will find it especially profitable to study the section of Stern and Castendyck's *The Handicapped Child* on "If your child is deaf or hard of hearing." She finds out as much as she can from the special teacher of the group.

The special teacher will share with her the responsibility for motivating and instructing the parents in their part in the child's education—how to understand his many limitations, how to talk to him, to encourage him to practice speech while at home, how to correct his speech without discouraging him, how to guard him against overfatigue and tension, how to meet his need for extra careful and patient explanations of anything new.

If he is being taught lip reading, parents will need help in learning to speak so he can best read their lips.

If an otologist decides a hearing aid may help, he or one of his staff will probably give the child and his parents first instructions on its use and care. For the continuous and intensive supervision that is required if its use is to be satisfactory, the nurse and the special teacher will have to carry most of the load. Protecting the child from expecting too much of the aid too soon, and from wearing it for too long periods at a time, is necessary if he is not to become discouraged while learning its use. Use of the right type of music to help him build up his ability to endure sound is one activity in which the home can participate very valuably.

The mere mechanics of keeping the hearing aid in working order is no small matter. Except with the very young child (some are fitted at the age of two), the more responsibility the child can take for its care and management, the better.

The nurse's responsibility for the child with impaired hearing is increased if there is no special teacher and he is trying to get his education in a regular classroom. Since this teacher can do so much less, both because she lacks the special skills needed and because of lack of time (the number of pupils taught in a special class is much smaller than the usual number), ways must be developed for others to give the child more help. One of the parents or an older

4. For the three- and four-year-old, whispered voice is a suitable means of testing hearing. Pitch range tests are unsuitable because threshold readings cannot be obtained before interest and attention lag.

5. Studies indicate that if a child does not respond to the sound of a voice by the end of his first year, deafness or gross defect is to be suspected.

In addition to the help the nurse can give such children individually, she can make an even greater contribution if she stimulates community interest in establishing an adequate program and proper facilities for conservation of hearing for this whole age group. Recent developments in objective audiometry and in diagnostic testing of young children, based on the theory of the conditioned response and the use of test sounds of known pitch and loudness, are making possible determination of the degree of hearing loss in very young children. Special equipment, highly trained personnel, and a great deal of time are required. General instruction of parents, family physicians, and nurses, to increase their sensitivity to the variations from the normal which indicate the child should be referred for such an examination, are also required if the program is to function.

Arguments for the value of hearing conservation for preschool children are even more self-evident than for other age groups, as it is in this period that children are learning the language, developing their behavior patterns, and establishing their personalities. Equally evident is the advantage of earlier treatment of the physical causes of deafness. Success in stimulating residual hearing, especially when it is greatly reduced, is lessened by delay. In some cases, proper audiologic work, supplementing the otologic, when begun early enough may result in improving the child's functional status sufficiently so that he can be educated in a regular school. Without it he would have had to be sent to a special institution.

In furthering the objectives of a school health program considered from even the narrowest point of view, the school nurse engages in few activities which accomplish as much as does the securing of early identification and treatment of these children. As with work on vision difficulties, improvement before school age is not only

to school employees who may develop hearing difficulties. Teachers especially find such a handicap frightening, and may hesitate to admit even to themselves that they are losing their ability to hear, and by delaying diagnosis and treatment make a bad condition worse. By making more generally known the legal rights of the deaf and hard of hearing for such assistance as they may require in order to secure needed physical and aural examinations, whatever treatment is indicated, and if necessary hearing aids, lip reading, speech correction, and auditory training, the nurse is not only rendering a valuable service to the adults who may be encouraged to take advantage of such opportunities, but she is making life better for the children dependent upon them in their roles as teachers or parents.

For both 16-year-olds and adults, individual counseling and guidance is available as a next stage to select for the pupil an appropriate occupation and for the adult a new line of work if the old one can no longer be carried on. Assistance in obtaining preparation for the work is also provided, with the individual paying all, part, or none of the cost, according to his circumstances.

Preschool deaf and hard of hearing children. Here is another field where service to the child before he enters school may be many times more valuable than what may be attempted for him after he enters.

On home visits the alert nurse may discover a preschool child with a serious hearing defect and may be instrumental in assuring the child a good start in life by seeing that he receives prompt medical attention and an early educational start. Much preventive work can be done before a child enters school. Some hearing tests which a school nurse can use are:

1. In the first three months of life, percussion sounds yield quicker response than the voice. A baby's response is usually reflex; for example, blinking, jumping, twisting fingers, etc.
2. In the third, fourth, and fifth months, voice gains steadily over percussion sounds in winning quick response.
3. Children over one and one-half years respond to simple speech tests. Quiet rather than loud voice wins interest and attention.

his classmates, and giving full recognition to indications of his abilities as evinced in any other way than recitation.

If no one else is concerned with recruitment for potential speech correctionists, the nurse can send for and include in her vocational information on the health and welfare occupations material pointing out the possibilities in this pioneer field.

If there is a teacher's college in reasonable distance of the school system in which she is working, the nurse may be able to work up a project for a survey of the pupils in her schools with the speech correctionist there to give field experience to the students.

There may be a "service club" looking for a new and different project to sponsor, who might underwrite importation of a specialist to head up a first survey to point out the extent of the problem.

Children with allergies. A larger proportion of children under a school's supervision fall into this category than into any of the other groups discussed in this chapter. Here, as is true with so many other causes of children's disabilities, the school's greater difficulty lies with the lesser rather than with the more severe cases. Severe cases have usually been identified and put under treatment before the child entered school, for although an allergic disorder may develop at any age, a susceptible person usually manifests some indication of it in childhood. Here is another area in which preschool and family histories may give very helpful data. Estimates of medical authorities vary from 50 to 75 per cent as to the proportion of allergic children who show family history of allergy. Estimates as to the number of children in the school population who may be expected to show symptoms of allergy also vary widely, according to the authority, from 10 to 35 per cent of the total group.

There may be many more whose disabilities are not recognized as allergies, and these are a special responsibility for the school nurse. In meeting this responsibility she must face in two directions. She must try to locate children who are allergic and get them under treatment; at the same time she must protect those who may or may not be allergic from amateur diagnosis as such by parent and teacher. In the case of children whose diagnosis is established,

achieved more easily, but saves the child unnecessary discomfort and often actual suffering. It reduces the danger of development of personality difficulties resulting from the disability, and increases the chance he has for educational success. At the same time, the usual economy of time and effort results when preventive rather than remedial action is secured.

Children with speech defects. As indicated in the discussion on screening (see Chapter 9) the most serious problem in connection with these children is the lack of concern about them. For those that are identified, however, the nurse has definite help to obtain for them. The 1.5 per cent that may be expected to be found in a school population, where the speech or voice disorder is associated with a serious hearing loss, can be identified when a hearing testing program is in operation and they will be brought to proper attention if the follow-up functions in that area. The one in two thousand where the defect results from cleft palate or harelip can be identified in the course of the medical or dental examination, if not before, and can be cared for if the parents are unable to do so, through local welfare or health department and utilization of United States Children's Bureau's funds for the purpose.

"Stuttering" is the preferred term to cover both stuttering and stammering as previously used. For the six in a thousand who stutter, there are several things the nurse may do to help them out of their difficulty. Assuring the child and his parents that this defect is not associated with either physical or mental abnormality is a first step. The next is to help them see that the condition has been caused by unnecessary worrying about perfectly normal imperfections in childhood speech. When the parent learns to listen to his child with interest and respect and succeeds in making the child feel that interest and respect, the third step has been taken.

The teacher can cooperate by sharing this attitude of the parent and cooperating with the child in his avoidance of embarrassment, allowing him to give other evidence of preparation of his assignments than through class recitation, when that proves too much for him, but always encouraging him to participate in all activities with

done to help the child. Because so few children "die of allergy" and so few even go to bed with it, she finds other parents who are willing to ignore the condition. To such parents she explains that if a condition proves to be allergic, it is very important to have early examination, diagnosis, and treatment. The sensitivity of the child's body tissues to some substance he eats, drinks, touches, or breathes may at first be so mild it is almost unnoticed. If it remains undetected and untreated long enough, however, it frequently develops into a severe reaction. The child with a mild digestive upset from an allergy may later develop chronic diarrhea; the one with occasional hives may develop a continuous eczema; the one who had a slightly running nose may develop asthma.

Those individuals (school personnel as well as children) who suddenly become allergic to something they have encountered daily for years without harm (a botany teacher of 50 may develop a new and acute reaction to certain pollens), the nurse can serve by directing them to early medical care.

The nurse explains to the parent that an allergic child may become actually handicapped by his condition and shut off from many normal participations, from many types of work, from joys of play, and even from friendships. Both respiratory and skin reactions repel some people and also cause feelings of inferiority in the individual afflicted.

To parents who are already doing their part in taking care of an allergic child, the nurse gives assistance by helping prevent contact with undesirable substances and in dietary guidance, if meals are eaten in school. In short, she helps the school give the child the same protection while he is there which the parents provide him at home. She keeps his particular needs in mind when his group is about to undertake a new activity. She asks for a special order from his physician for indicated changes in the school program, such as use of the school swimming pool. For an asthmatic it may be too cold; moist or weeping eczema may become infected; chlorinated water may be irritating; if water gets into the Eustachian tube the child with an allergic nose is particularly liable to middle ear infection.

there is an added danger of amateur diagnosis of the cause, again by the parent or teacher, as being "emotional." If this is accompanied as it so often is by the belief that the condition is under the individual's control and all that is necessary is that he should "make up his mind not to have it," the child's condition may be greatly aggravated both by delay in securing needed treatment and the unsympathetic attitudes around him.

The nurse keeps in mind the strong influence of emotions on allergic reactions in her health supervision of the adult employees of the school system as well as of the children. She realizes what lay people often do not—that these reactions may be strongest when the individual himself is unconscious of the intensity of the emotion within him which may be generating from a certain fear, resentment, or worry which he is attempting to ignore. The fact that a person who has hitherto appeared nonallergic may first show symptoms of a severe physical allergy when emotionally disturbed contributes to a lay person's impression that the whole thing is simply a matter of controlling one's emotions. Actually even in mild cases, the embarrassment, inconvenience, and discomfort to patients who have frequent attacks may be sufficient to cause them to become discouraged and even depressed, while the extreme misery and real suffering in severe cases have even more serious effects on the mental state which in turn makes worse the physical condition.

The only way a nurse can obtain any satisfaction from her work with allergy problems in the school is by establishing herself as an interested student of the subject. If she attempts the role of an authority she can probably get herself involved in serious difficulties. The most valuable contribution she can bring to the health and comfort of these children is her power of trained and scientific observation and her alertness to suspect possible causes and effects in any new developments in their reactions. Increasing the ability of the parents, and when indicated of the child himself, to improve the quality of their observations is another possible service.

In the nurse's follow-up of allergic children, she finds parents who are already well informed, intelligently concerned, carrying out excellent medical advice, and anxious to do everything that can be

With some parents the nurse's emphasis may need to be against, instead of toward, restrictions. Since allergies are somewhat familial a certain parent may attempt to supervise his child according to his own experience or treatment when he was a child, instead of obtaining and following treatment based on the child's own condition. Because there were certain foods he could not eat, he may forbid them to the child. Other parents, though the child is under care of a physician, ignore him and use their own initiative by cutting out of his diet certain foods of which their observation makes them suspicious, and failing to substitute other foods thereby contribute to eventual malnutrition.

The nurse explains to the parents the necessity for a careful and complete study of all causes of allergy in the child. Then those which can be are eliminated from diet or environment. For some causes, such as pollens, molds, house dust, animal emanations, the physician may wish to use injections for increasing tolerance or obtaining desensitization. Prompt treatment of symptoms protects the child's comfort, rest, and nutritional development. Then if there is unfortunately any one allergen which cannot be controlled, he will tolerate it better if the total threshold of hypersensitivity has been raised.

The allergic child may have abnormally severe reaction to insect bites and stings. It is important to know what insect is responsible in order to treat the condition.

During his school life new casual allergins may appear. Three factors are involved: the hereditary pattern, extent and duration of exposure, properties of the allergen itself. Girls use new cosmetics, boys go to barber shops, new materials appear in garments, new foods are eaten.

Eyelids are one of the most sensitive areas and are often affected by substances carried to them by hands as well as by dust, pollens, and chemicals. Chronic allergy should be given consideration in wounds that fail to heal properly. Special tetanus antitoxin, sometimes urgently indicated, but made from other than horse serum, is desirable for some.

When it appears that the patient needs professional help to take

She contributes in another very important way to the protection of children's personalities by use of this same professional judgment. By being equally sensitive to early indications of adjustment or mental illness problems of adults who are dealing with the children, parents and school staff, the nurse may help these adults to develop an objective attitude toward their own difficulties and to secure professional attention promptly, thus lessening possible effects upon the children.

Another protection she may be able to give the children is discouraging too casual application of diagnostic labels on children who are essentially normal but who may show socially unacceptable behavior which hints at a neurotic or delinquent possibility in the future. While attention as a preventive measure is needed, the symptoms may be only exaggerated forms of behavior common to all children at one age or another. They may be actions which persist too long after they should have been outgrown or which, though the child had developed beyond them, later reoccur.

The nurse may see the same kind of neurotic conflict in two children; in one the conflict may result in a physical illness symptom, in the other, it may produce symptomatic behavior.

When the child is having difficulty adjusting to his environment or in his interpersonal relations, the nurse works closely with classroom and home room teachers, the school guidance service, and with parents and the family physician to plan remedial measures which can be carried out by the home and school working together. Success of these measures is in proportion to the sensitivity of those who work with the children and the promptness with which they observe such things as shyness, seclusiveness, reluctance to take part in games or classroom activities, quarrelsomeness, and boisterousness in excess.

For the child who must be referred for psychiatric study, the nurse has two important services to offer. One is the assistance she may give him and his parents in helping them accept treatment. She is a person already accepted by both parents and child as someone who is sympathetic and concerned with their problems. A careful, accurate, and comprehensive history with detailed observa-

Chronic fatigue may cause sleeplessness, irritability, and loss of appetite; in reverse, each of these three conditions or a combination of them may be the cause of the chronic fatigue.

The American Psychiatric Association in its *Statistical Manual* classifies the primary behavior disorders of children in these three groups:

Habit disturbance. Indicate symptomatic manifestations, e.g., nail biting, thumb sucking, enuresis, masturbation, tantrums.

Conduct disturbance. Indicate symptomatic manifestations, e.g., truancy, quarrelsomeness, disobedience, untruthfulness, stealing, forgery, setting fires, destructiveness, use of alcohol or drugs, cruelty, sex offenses, vagrancy.

Neurotic traits. Indicate symptomatic manifestations, e.g., tics, habit spasm, somnambulism, stammering, overactivity, fears.*

In elementary schools the number of children requiring psychiatric treatment is relatively small, but in the secondary schools there is a sharp rise in the number, including some who even require hospitalization. Most of these, if an authentic history is available, can be shown to have had various signs of lesser maladjustment in earlier years. This indicates that more attention to early indications in the elementary school would have been profitable.

There is a marked increase in behavior problems as the intelligence level moves from the average in both directions. The incidence is greater for the below normal group than for those of superior intelligence. This suggests it might be wise to protect from, or give more adequate preparation for, the complicated teaching and social situations which confuse the children in the strenuous high school organization of the present day.

The nurse's experience and professional training enable her to be especially sensitive to personality deviations which are serious enough to merit referral for help more skilled than she or the teachers can offer.

* American Psychiatric Association, Committee on Statistics: *Statistical Manual*, 6th ed. National Committee for Mental Hygiene, New York, 1934. 59 pp.

careful questioning regarding the parent's own observations to have a statement of the problem come from the parent. One of the nurse's valuable services is to help the parent see this as just one more physical condition for which medical or surgical treatment may be of value. Since not only treatment but even diagnosis is apt to involve specialists, travel, and other expensive procedures, the nurse's help is needed in making such arrangements more often than in some other fields.

Pregnancy and suspected pregnancy. Rumors of pregnancies are prone to develop in wild profusion whenever there has been one actual case, and at other times for no apparent reason. Prompt action is demanded to protect innocent girls and to give immediate health supervision to those who need it.

If a group or a large number of individuals are involved in the rumors, they may be called together, the situation described to them with a statement of the necessity—both for the good name of the individuals and of the school—that the principal has information that will enable him to refute the rumors. A discussion of the problem with the group will usually bring the suggestion from one of the number that they do as they have been accustomed to do when a question concerning their health status arises—ask their mothers to take them to their family physicians for a check-up. If the suggestion does not come from the group the nurse can make it. The girls will appreciate the value of a procedure that will make it possible for the principal to announce that reliable medical evidence is in his hands to prove the gossip without foundation. Individuals who do not bring their physicians' statements are then handled individually.

When suspicion is pointed at just one girl, the nurse's first action may be to seek an individual conference with her on some pretext. A study of her weight record may give a basis for her concern (either a loss or a gain may be associated with the situation). Or, "You don't look as well as usual," "Are you worried about something?" "You seem nervous lately," "Miss Blank says you aren't doing your work as easily as usual; do you feel well?" may give the pupil a chance to confide in the nurse. The same principles are

tions of his functioning—physically, emotionally, and socially—is needed if his motivations and behavior patterns are to become evident. These studies are essential in the same way that the physical and psychometric aspects of the examination are. Often the nurse's knowledge of the family and the confidence they feel in her enable her to get a more comprehensive history than would otherwise be possible.

When a diagnosis is made and treatment prescribed, the nurse participates in carrying out the recommendations made. She follows the progress of the child and is ready to help get him back into school when that is indicated.

Hermaphroditism. True hermaphroditism offers no problem to the school. It is very rare and when it occurs is self-evident at birth.

As with so many problems of child health it is not the extreme or acute case which presents difficulties to the school health service. It is the borderline and especially the undiagnosed case. "Statistics indicate that pseudohermaphroditism occurs once in 1000 persons." * Many of these do not come to attention until after the child is of school age. Sex may be misinterpreted at birth, for while the gonads of only one sex are present, abnormalities of the external genitalia and secondary sex characteristics may indicate the opposite sex. Then as the child grows older secondary characteristics or functioning of the true sex may be manifested with severe health and emotional implications for the child and perhaps some difficult social situations for the school and for the child's family.

The first problem is intelligent and early observation of any indications of abnormality. The next is to secure diagnosis. If the nurse learns that the family has a trusted family physician whose relationship with the family goes back many years, the approach may be through him. Usually, however, an appointment with the school physician, under conditions where the parent will feel complete protection of privacy, is desirable. If this is impossible and the nurse herself must take it up with the parent, it is often possible by

* Young, H. H.: *Genital Abnormalities, Hermaphroditism and Related Adrenal Diseases*. Williams & Wilkins Company, Baltimore, 1937. 649 pp.

in order for their future protection. Therefore, especially in the case of an inexperienced nurse, it is often wise to call upon specialized social workers for advice and guidance early in the episode before the situation has become too involved by well-meaning individuals doing the wrong thing. Advice may be sought even though the case is not formally reported.

"Crippled" children. Definitions of a "crippled child" vary from state to state and from agency to agency. For the purpose of this discussion, it will include those children who have been injured permanently or temporarily to a degree which interferes with normal activity, due to accidents, birth injuries, congenital defects, bone and joint tuberculosis, osteomyelitis, infantile paralysis, or rickets. Others sometimes included but which will be discussed separately here include those due to rheumatic fever and heart disease, epilepsy, diabetes, and sometimes defects of speech, hearing, and vision.

With these children as with those having the handicaps previously considered, it is the promptness of discovery and immediate, unceasing follow-up to secure a correct diagnosis and early treatment which mean more to the afflicted individual than does any amount of intensive service later on.

Conservative estimates of the number of crippled children vary from one-half million to a million. Delay in getting them to treatment often intensifies the difficulties or secondary conditions which develop as result of the original handicap. Compulsory registration of children born with congenital defects would help if it were accompanied by provisions for definite assignment to a specified state agency of responsibility for continued supervision and treatment at proper stages of the child's development. This would guard against the danger of the child becoming "lost" to the follow-up agency. It would also mitigate against the duplication of work which so often occurs under present conditions when the family moves from an area just at the moment when all arrangements have been completed for a surgical treatment. The whole process must be begun over again in a new community by a new set of workers.

For many children, discovery of the ailment at school entrance

applied as in dealing with any health problem of a minor; the parent is considered responsible and assistance is given the parent in meeting his responsibilities if necessary. If the parent fails to assume his responsibilities it may be necessary for the child's welfare for authorities to step in.

If the fact of pregnancy is established the case is less difficult to handle. The nurse's first concern is to make sure that the girl is under medical supervision to ensure protection of her health and that of the unborn baby. Her next concern is to determine that maximum "social protection" is being planned for both mother and child. This includes protection from avoidable gossip, arrangements for living conditions during the prenatal period that will strengthen the girl's character rather than break it down. For the unborn child it includes legal determination of paternity. If marriage is a possibility, careful consideration is required of all factors involved before a decision is reached. After the birth, constructive plans for mother and child present many difficulties.

The help of social workers specializing in this intricate and delicate field is eagerly sought by even the most experienced nurses. If the family is Catholic such a specialist is available from the Catholic Charities Aid; for others the Church Mission of Help is generous in assisting. The day is past when a school administrator felt he had discharged his obligation to such a girl when he "expelled" her from school as an object lesson to others. Instead every encouragement is given her to complete her education later, if necessary, through transfer to a school in another community.

In addition to a study of the pupil's health status, a study of her social situation is very much in order. If she is pregnant, there may have been a lack of home supervision which needs to be remedied. If she is not pregnant or if the determination has not yet been made, a study is in order of what her behavior has been to make her subject to such accusations. Certain cases must be reported to the Children's Court.

The help of skilled social workers may be valuable in cases where pregnancy is found not to exist but where the social habits or environment of the girls concerned is such that preventive work is

are definite concrete indications of it, measurable and evident to all. Even when a condition itself is irremediable, there may be nursing care which will increase comfort; there are possibilities of special education which will improve the situation for the child and for his parents and in the provision of which the nurse may have a part.⁽³⁾

Fewer occasions occur to give the nurse a sense of frustration when dealing with these children than she encounters when working with those with some other conditions. Working with her on this child's team are not only the child's parents and teacher and a local physician but rich resources of consultants, educational, medical, surgical, and nursing, physiotherapeutic and material resources in generous measure.

The Children's Bureau, Federal Security Agency, provides seven and a half million dollars a year for services for crippled children through grants to state crippled children's agencies. Thirty-two of these are state health departments; ten are state welfare departments; four, crippled children's commissions; three, departments of education; and four are state university medical schools or hospitals. The 1950 *Current Program of the Children's Bureau* (4) states:

The State staff usually include physicians, specialists in orthopedic and plastic surgery, orthopedic nurses, medical social workers, and physical therapists. State and local health departments, welfare departments, vocational rehabilitation agencies, and school authorities cooperate with the State agencies administering the services.

Each State crippled children's agency maintains a register of crippled children; approximately 510,000 were registered on December 31, 1948. Diagnosis and some treatment is provided in clinics held in permanent clinic centers, or at intervals in itinerant clinics. When hospitalization and medical and surgical care are needed, the State agency assumes responsibility for arranging for care at a hospital as near as possible to the child's home and for obtaining the services of the physician or surgeon. Plans are made for his subsequent care in a convalescent home or in his own home, and for medical and public health nursing supervision and physical therapy to complete his physical restoration. Medical social service is provided also to aid the children in adjusting at home, at school and in neighborhood activities. Children for whom such opportunities are

is too late for successful treatment. There are other children who are not discovered even then as the parents may hide them, if ignorant of the possibility of treatment, thus concealing their "disgrace." It is essential that all community agencies with workers going into homes should unite in their efforts to locate and keep under continuous supervision all crippled children.

Due to the present effective emphasis on rehabilitation, we are seeing larger numbers of crippled children in regular classrooms, including those with defects of greater severity, than were formerly attempting life in a normal environment.⁽²⁾ The nurse helps these children and their parents anticipate the complications that will arise as the pupils move from grade to grade, then to junior high school and senior high. Each move means new schedules, additional activities, and particular conditions which may be difficult for a handicapped child to meet. Sometimes preliminary planning will provide special arrangements which will allow the pupil to continue with his group. When this is impossible, the emotional shock may be lessened if the difficulty has been anticipated and a substitute activity has been arranged.

The nurse works closely with the educational and vocational advisors so that they will be kept well informed concerning the prognosis for the pupil and be alert to his assets which may be hidden, as well as to the limitations which may be so much more obvious. Such advisors are often valuable in discovering possibilities for extracurricular activities which might be overlooked by personnel lacking their special preparation. Early choice of at least the general vocational field toward which the education of the child should be directed is especially important as he may already have lost time from school and be behind others of his age group.

Working with these children, the nurse finds unusual opportunities to get justified satisfactions from her efforts. This is not because these are apt to be "easy cases," for on the contrary they are characteristically long continued, difficult, and often complicated by secondary problems resulting from the primary one. They do, however, allow the nurse to use her nursing skills; many services are required which only a nurse can give. When progress is made, there

An excellent pamphlet for parent, teacher, or nurse is published by the Public Affairs Committee. It is *Help At Last for Cerebral Palsy*.⁽⁷⁾

Rheumatic fever and heart disease. Rheumatic fever is the cause of 95 per cent of childhood heart disease. Of the few congenital heart cases who live to be of school age, a very small proportion attend school and they usually do not remain for long unless of the fortunate group profiting by the recently developed surgical treatment. Those in school are usually already known to the family and family physician. They come with specific recommendations for variations in program, and special provisions for their comfort, safety, and happiness are arranged by the school staff.

Generally the families will have had adequate guidance as to the amount of activity desirable for them. In cases where decompensation has not been observed, however, the family may not have been informed of a moderate congenital cardiac condition. If such is discovered in the course of the periodic examination by the school physician when the parent is not present, a routine notice is not sent but the physician or nurse discusses the matter with the family physician or parent. The nurse keeps in mind the child's particular susceptibility to subacute bacterial endocarditis and to general pulmonary tuberculosis. Extra efforts are made to protect him from infections and communicable diseases. Any activity is carefully prescribed and supervised.

The increased emphasis on rheumatic fever in school children has occurred not because of a greater incidence of the disease but because, as deaths from other communicable diseases have been reduced in this age group, the spotlight has moved to rheumatic fever. Excluding accidents, heart disease and rheumatic fever are the leading causes of death in ages 5 to 19.⁽⁸⁾ But since 1920 its mortality rate has decreased approximately 70 per cent for white children ages 5-14, and 60 per cent for those aged 15-19. For non-white children, there has been a 25 per cent decrease in the 15-19 age group while the rate for the 5-14 group has remained about the same.⁽⁹⁾

There is as yet no specific preventive as its cause is unknown.

appropriate are referred for vocational training when they reach 16 years of age.

In addition to this type of assistance for children through the state agency, the Children's Bureau is a resource for the nurse where she may obtain expert advice and information concerning specific problems in this field. Its many pamphlets and reprints will usually include one on the subject desired. There are those also especially written for parents, which she uses to supplement her spoken words.

For vocational rehabilitation problems in individuals 16 and over which may include pupils as well as school employees, there is comparable printed material available from the Office of Vocational Rehabilitation, another Federal Security Agency service.^(5, 6)

For a good many years, private interest groups such as committees of the Elks, Shriners, Rotarians, and many others have furnished special services of great variety to crippled children. More recently, complete programs, beginning with case finding and carrying through with plans for treatment, special education, recreation, rehabilitation, and employment have been developed by organizations such as the National Foundation for Infantile Paralysis which is concerned with those crippled by polio, the National Cerebral Palsy Parents Council and the American Academy for Cerebral Palsy (made up of physicians), of the National Society for Crippled Children and Adults, which offer materials and advice for parents and physicians, respectively.

The International Council for Exceptional Children, a department of the National Education Association, 1201 16th Street, N.W., Washington 6, D.C., publishes the *Journal of Exceptional Children* which includes material in relation to the education and welfare of handicapped and gifted children. This is designed specifically for teachers but it is read by many parents also as its language is mostly non-technical.

These national groups have local chapters in many sections of the country. If the nurse is unfamiliar with the location of the ones nearest her, a request to the national offices will bring her the information.

not clear cut; it cannot be made with certainty if none of the major manifestations is present. Diagnosis and treatment of SUSPECTS are equally important, however, and it is in this important area that the school and the school nurse have a unique contribution to make. There is as much heart damage from mild attacks as from cases which at first appear more serious.

The actual infection, rather than the heart condition resulting from it, causes most of the deaths of school age children; others are crippled by it, with a mechanical damage to the heart or damage to the nervous system as in chorea. The first attack usually comes when the child is seven or eight years old and very frequently attacks him again and again during the school years. The nurse, therefore, watches particularly for migratory polyarthric pains; enlargement of the medium-sized joints—ankles, knees, wrists, and elbows; persistent low-grade fever; persistent tachycardia (about 130 a minute); mild leg ache or joint pain—"growing pains." These are more significant if the child wakes up with them or has them in the morning than if he develops them later in the day when they may be from fatigue. Epistaxis, abdominal pain, particularly over or in front of the stomach, lack of appetite, listlessness, macrocytic anemia, and undue fatigue are other signs and symptoms. The purpura of rheumatic fever can be differentiated from other rashes as it cannot be blotted out by pressure.

In this program, as in so many for the school child, there is great value in the nurse's teaching of others to take their parts, as well as in what the nurse does herself. She helps parents and teachers to become sensitive to these symptoms and to realize the importance of noting and seeing that they are followed up.

The nurse's next educational step is to convince the parent of the urgency of getting the child under medical care even though "he doesn't seem very sick." If hospital care is indicated, she assists the physician in convincing the parent that it is necessary in order to secure the laboratory tests and other studies for which hospital equipment is essential.

Unless the home offers unusual facilities for the child's care, the next step may be to explain to the parent the need for convalescent

Therefore, emphasis in the school program for its control must be on early discovery, prompt diagnosis, persistent treatment, and continuous, intensive supervision. Its frequent concomitants are poor nutrition and low living standards. Morbidity studies have shown its incidence to increase among individuals aged 5-24 as income decreased and as households became more crowded.⁽¹⁰⁾

Current research in this field with resulting changes in treatment and program requires that the nurse doing school work keep herself informed concerning new information and recommendations. She may obtain current material from such sources as the Government Printing Office, Washington, D.C., her local and state health departments, and the educational services of life insurance companies. If she is not familiar with the local or state chapter of the American Heart Association, she may obtain its address by writing to the national office at 1775 Broadway, New York, 19, N.Y. Through a local affiliate or chapter she may obtain not only reliable printed material but, according to the various programs, assistance of many kinds. She may also have the privilege of participating with the group in developing additional services that may be needed locally.

Although rheumatic fever is next to tuberculosis and syphilis among the chronic infectious diseases, it is not reportable to the health department in most communities. The school keeps its own special file of the children, under its supervision, who are known to have had the disease, and the nurse and administrator may help stimulate the development of an inclusive community register as well. About two thirds of the children who have had the disease develop some sign or symptom of heart disease, and development of a plan for community reporting and central registry of cases is desirable, for although the largest proportion of cases occur during school years, many of them reoccur in later years and new cases do appear both in preschool and postschool years. Information regarding present cases is essential to stimulate establishment or expansion of facilities for the examinations and tests necessary for cardiac evaluation and for adding a school cardiologist and a cardiac clinic.

The disease is so varied in its manifestations that diagnosis is

family, and it may be desirable to refer brothers and sisters for a diagnostic examination also.⁽¹²⁾

As long as the child is out of school, the nurse continues her contact with him and his family. Then, and after his return to school, she encourages the parents to seek a continuous and intensive health supervision from the family physician or clinic. The amount of school adjustment depends on the cardiac classification and the recommendations of the physician. Such a classification is set up by the New York Heart Association, 2 East 103 Street, New York, N.Y. Class II cardiacs will need adjustments as to strenuous exercise, stair climbing, etc. In some cases, rest and transportation will be needed.⁽¹³⁾

On the return to school, the nurse helps the child and his teachers to consider him as a normal person again, rather than as an invalid. The amount and type of physical activity for the individual child are based on the attending physician's instructions. The present trend is toward more activity in the quiescent stage of the disease than was the custom in the past. He is examined regularly and given all possible protection against reinfection with immediate treatment of any illness or defect. Community resources may be taxed to protect him against damp and crowded housing, poor food, lack of rest, inadequate clothing, and most of all against emotional strain. Though an excessive amount of the nurse's time and energy may seem to be absorbed by these problems, such expenditures should not be begrudged as any solutions attained will help safeguard child health for others as well. In densely populated areas, group work may be done with parents of cardiac children, to increase their knowledge of the disease, to teach them nursing procedures and simple arts and crafts which they in turn may teach the children as activities while in bed.⁽¹⁴⁾ Many community agencies may be involved in such a project.

Success in school and out with these children depends upon effective coordination between parents, child, family physician, school physician, school administrator, teacher, nurse, public health officials, social workers, and community organizations. Anything which can be done to prevent throat and upper respiratory infections

home care with its isolation to protect against respiratory infections, the 24-hour health supervision and regime set up for the child's protection. This is done as soon as he can be taken from the hospital. As he convalesces, there is the added advantage of group play. Education and graduated physical activity are possible here also under trained supervision.⁽¹¹⁾

Such convalescent homes are lacking in many localities. The nurse may participate in community education directed toward establishment and support of such necessary facilities as few people are in a position to appreciate the need so keenly.

While cases of rheumatic fever do occur in families living in average or superior environments, they occur more often in lower economic, social, and intelligence groups than in higher. This may mean that his home with lack of space for his isolation, of proper food, and of skilled care is an undesirable place for his convalescence, so that if no convalescent home is available, foster home care may be indicated.

To parents who can care for the child in their own home, the nurse is valuable to help them plan their arrangements, to demonstrate nursing procedures, or to give them information of agencies that will give or teach nursing care. She contributes to the child's and parent's morale by emphasizing the temporary nature of the acute stage, the reason for and the value of various restrictions, by suggesting suitable activities and amusements, and by helping to arrange for home teaching. While the part emotional factors may play in the causation of rheumatic fever is not established, there are evidences that emotional disturbances and maladjustments are definitely related to its reoccurrence and the amount of crippling resulting from it. Bed rest, prescribed to protect the heart, may cause an emotional state which affects the heart more than would the physical activity which the bed rest prevents.⁽¹²⁾

As in tuberculosis, there is a familial incidence. This may be due to heredity or to a mutual malnutrition, mutual exposure to infections, or mutual reaction to the same environment. The nurse's study of the home environment is especially important. The control program, as in tuberculosis and syphilis, is centered on the

The nurse's first obligation to these children is to be sure that they have been thoroughly studied and diagnosed with utilization of the best medical services available. The nurse may explain the EEG test—the electroencephalogram—to the parent and when indicated to the child, as a record on a piece of paper of the tiny electric current or waves which flow back and forth over the surface of the brain of each of us; that the study of this record by a specially trained physician may tell a great deal about the child's condition and help determine the treatment which will be most helpful. If a lumbar puncture is needed, she may compare the taking of the pressure of the spinal fluid with the blood pressure measurement with which almost everyone is now familiar. Removal of spinal fluid for examination may be compared with the taking of a drop of blood from the finger or ear lobe for examination.⁽¹⁸⁾

The nurse may contribute to the success of the examination by supplying as complete a personal and family history as can be obtained. From the beginning of her work with the parent or child, the nurse avoids the use of the word "cure" and refers instead to the prospect of "relief" or "control" of the seizures. The nurse persists to obtain a medical study of every child with "spells" of any description, emphasizing to the parent that the earlier treatment is begun, the more successful it is apt to be; that skillful and persistent use of medicines now available can control or greatly reduce seizures for the majority of children; there is no one medicine which will relieve all cases. Certain medicines are especially good for certain kinds of seizures. Spells of petit mal—a brief lapse, sometimes of only a second or two—which were formerly very resistant to treatment are now treated by drugs such as Tridione and Paralidione, which completely relieve a third of the cases and greatly benefit another third. Though petit mal is a form that may disappear as a child grows up, it has been responsible for school failure of many children. Since the teacher did not understand the physical cause she was apt to consider the child's inattention as a voluntary insult to classroom procedure. The child feeling the injustice of her attitude but being unable to justify himself would naturally

in the associates of the child who has had one attack of rheumatic fever may be a contribution to prevention and control of the disease. Three school procedures which may help in this are: training of parents to keep at home any child with a sign of a sore throat; immediate exclusion of anyone—pupil, teacher, or other employee—who appears in school with a sore throat; emphasis on including in each pupil's health record notes on any sore throats.

When the child with a damaged heart becomes 14, he may be reported to the State Vocational Rehabilitation Service so that he may be guided into preparation for an occupation with minimum hazards for him. This is especially needed when he comes from a family which would ordinarily expect him to leave school as soon as he became eligible for working papers and whose usual prospect would be unskilled labor.

The nurse who is interested in contributing to research and to school-community cooperative action while improving local service to school children will find unusual opportunity in connection with her work for cardiac children. The size of the problem, the lag between knowledge and practice existing in most communities, the dramatic possibilities of prevention and rehabilitation, and the strong appeal to public sympathy make this area a fertile field for research and joint activities. A study of projects developed in San Bernardino County, California,⁽¹⁶⁾ Newark, N. J.,⁽¹⁷⁾ and in Denver, Colorado,⁽¹⁸⁾ will give her a picture of some of the practical possibilities.

Seizures. The possible causes of seizures are many. They include such serious conditions as brain tumors and cysts, scars of the brain cortex, subdural hematomas, hypoparathyroidism, pseudohypoparathyroidism, apoplexy, and some fifty others; some serious, many of minor importance, some temporary only. While the causes of the majority of cases that prove to be epilepsy may remain undiscovered, they are usually due to abnormal physiology rather than to structural damage to the brain. Few require brain operation.

remiss in her lack of "doing things for him," it will help a great deal to give her a sense of adequacy. She will find she need not worry about lifting him since he is safest on the floor, with a pillow or a bundle of clothes under his head if needed to protect him should he try to beat his head on the floor. She will not need to worry about trying to restrain him as he should not be restrained. She need not worry about getting a doctor before it is over as it will ordinarily be over before a doctor could be obtained. She learns he will not die of a single convulsion and if he has a series, the doctor can be obtained before he would die of exhaustion. She will see that no serious harm results if his jaws are so tightly clenched that it is impossible to insert a firm soft object to keep him from biting his tongue. Experience with "pressure points," now shared by so many in first-aid instruction for control of hemorrhage, may make it easy for her to learn to use a firm upward pressure with her finger tips under the jaw in the middle and just in front of the windpipe to lift his tongue if he seems to be choking. Rolling him on his side so his face can be turned sideways allows the saliva to drain out of his mouth and is another way to make him more comfortable.

The teacher is entitled to expect that the seizures will be few in number. At least four out of five with proper medical supervision can remain in school if teacher and associates of the pupil are properly prepared and understanding.⁽²²⁾ If the child is not kept under medical care or if in spite of all possible treatment, it proves to be the rare case where seizures cannot be controlled, other plans must be made for him. If the parents' wrong attitude is the problem, foster care or a period at camp may be desirable. For those whose seizures cannot be controlled, home instruction, if it can be arranged, is preferable to placing him in an institution. If his own home is unsuitable, an attempt may be made to arrange for his care in a foster home. For such parents or foster parents, *Science and Seizures* written by Dr. William D. Lennox is especially designed.⁽²³⁾

When an epileptic is transferred to a new school group, it may be desirable for his classmates to be informed by the teacher, school

Epilepsy League, Inc., 130 North Wells Street, Chicago 6, Illinois, will show her many publications and reprints which she will wish to have in the faculty's reference library or in her own collection for loan to parents. Through this organization can be obtained the publications of the two organizations which united to form it—The American Epilepsy League, Inc., and The National Association to Control Epilepsy.

The league does not give direct service to epileptics, but members of its professional staff will answer inquiries from professional and lay persons concerning the true facts about epilepsy and its related social problems. The league works closely with the International Council for Exceptional Children to develop special services for epileptic children in the public school so that those children with a limited number of seizures may be placed in regular classrooms, and those with more frequent or severe ones may be provided special classrooms. Another aim is to secure adequate medical care for each such child. Effort is being made to have effective service available within a reasonable distance for all as is now available only in a few large centers, such as those in Chicago, Boston, New York, and Baltimore in connection with large medical centers, and in a few states which have traveling diagnostic and therapeutic facilities.

To break down the myth that epileptics cannot function on jobs, the league is cooperating with the divisions of vocational rehabilitation in the various states. Other functions are to further research and to help persons with epilepsy achieve a better understanding of their illness.

When the child reaches fourteen and becomes eligible for vocational rehabilitation, the nurse should make sure he has been reported so he may have the benefit of vocational guidance in planning his high school work toward preparation for an occupation desirable for him. When necessary, he should be given assistance in carrying out such plans.

Cancer. This is considered a disease of adult life, since only 1.5 per cent of the total number of deaths from cancer at all ages occur before the age of 20.⁽²⁵⁾ However, several times as many

physician or nurse as to what may be expected and how they can best help. An occasion like this may be utilized to help change the public attitude toward epilepsy to help these future citizens realize that just as many of them have some limitation or other, some physical disability (eyes and teeth affect such large numbers of children that they are nice illustrations to use), this child has certain difficulties of another kind. The child who has a preliminary aura leaves the room before a spell occurs. Plans are made for him to be accompanied by a previously designated person. A child whose desk is nearby may have responsibility for caring for a well-padded tongue depressor, sealed in an envelope for cleanliness, for the epileptic for whom this is needed. With the example of a well-poised teacher and a knowledge that their classmate is not suffering during his seizure, even young children quickly learn to accept attacks with little disturbance.

The findings of intelligence and aptitude tests may be helpful in encouraging the child, his parents, and his teachers. Studies indicate that the distribution of mental development among epileptics is approximately that which is found in the general population.⁽²⁴⁾ The great majority are normal except for their seizures, and only in the most severe cases does mental deterioration result. Those who have developed conduct and behavior disorders because of their illness (or because of the prejudices and fears of those around them) deserve special study and attention. Perhaps the health service staff with the assistance of the school guidance service can give them sufficient help, but there are instances in which the child guidance clinic or private psychiatric service may be needed.

Effective research is developing new diagnostic tests and methods of treatment for this disease so rapidly that the nurse must make a special plan to keep in touch with new developments if she is to be of the most help to the epileptic and also if she is to avoid embarrassment when discussing the subject with a concerned intelligent person. Dilantin, phenobarbital and Tridione may be replaced tomorrow by some whose names we have not yet heard.

The current list of publications available through the National

was twenty-five years ago, this is not because it has become more dangerous than it was but because of such factors as the lengthening of our span of life increasing the number who live to the ages when cancer is more prevalent, because more progress has been made in conquering other diseases, and because of improved methods of diagnosis which result in recognizing cases which formerly would have been missed.

The nurse stimulates interest of individuals in participation in the work of the local organization of the state division of the American Cancer Society whose national office is at 47 Beaver Street, New York, N. Y. She makes herself familiar with the materials, such as pamphlets, posters, exhibits, and movies, available through the local organization and specifically prepared for certain groups of the public as well as for high school classes.

Diabetes. Since this is not a reportable disease, only estimates and not statistics are available as to its prevalence. We know, however, that the number of children attending school with this condition is increasing. It is estimated that in this country one child in 8000 under fifteen years of age has the disease. A survey of 1,306,000 children under age sixteen in England showed 1 in 7000.⁽²⁷⁾ Before the use of insulin, the diabetic child usually died within a year or two of the development of the disease; now such children can be brought to adult life without invalidism due to their diabetes.⁽²⁸⁾ They are encouraged to attend school since with proper management the use of insulin allows them to lead normal lives.

However, these children merit special consideration from the school. School health examinations seldom include testing the sugar content of blood and urine; therefore, diabetes is not "discovered" in school. Nevertheless, members of the school staff are often the first to notice symptoms which may be indicative of possible diabetes and which warrant referral to a physician for the tests. Among these symptoms are frequent urination, extreme hunger and thirst, loss of weight, itching of the skin, unusual susceptibility to boils, blurred vision, faintness, and continued undue fatigue.

The school's first responsibility is to be sure these children are having intensive health supervision from family physician or clinic,

children do die of it as die of infantile paralysis so it is one of the things the nurse keeps in mind as she advises parents of children referred to her because of general or specific complaints. (24)

From ages five to ten, brain tumors and leukemia and, less frequently, kidney and eye tumors occur. After ten, bone tumors are most frequent and growths common to adults begin to appear. With the exception of leukemia, children's cancer may be arrested and even cured if diagnosed and treated early. Not all brain tumors are cancerous but even those which are not must be treated early if permanent damage to the brain is to be avoided. The nurse is suspicious of a sudden disturbance of vision, hearing, taste, or smell.

Persistent headache or explosive vomiting accompanies the onset of many childhood diseases but also may be indicative of brain tumor.

A sharp change in personality or lessened muscle coordination is a reason for advising the parent to seek a neurological examination.

Bone cancers appear at or near the joints of several long bones but more often in the knee and particularly in boys. Pain, tenderness, and swelling in such areas especially if accompanied by fever, loss of appetite, or night cries are reasons for prompt examination, as early diagnosis and treatment may save the child's life. Should the condition prove to be osteomyelitis, early treatment is equally valuable.

In her work with school staff members and as she has opportunities in her contacts with other adults of the community, the nurse is alert to guide them for early diagnosis; she also uses all possible occasions with individuals and with groups to improve public understanding of the real problems involved in cancer control. She has two main objectives in mind: to help secure early medical attention for anyone with cancerous or possibly precancerous conditions and to raise the general level of understanding and correct information about the disease in the minds of the people of her community. People need to know that it is not contagious or infectious; they need to have explained to them that though it has now become the second cause of death instead of seventh as it

York. It sponsors the *A.D.A. Forecast*, a magazine for diabetics and the general public. It assists local groups in organizing local affiliates of lay people to arouse and promote community interest in surveys for case finding and to serve the interests of diabetics. Some have sponsored special camps for diabetic children.

Material on diabetes is unusually attractive for use in health teaching on the secondary level. Information as to its cause and means of treatment and prevention are much more clear cut than in relation to many other diseases. It furnishes a good illustration of constructive work which can be done toward its prevention by teaching the public general principles which will also help preserve health in other ways, such as weight control, periodic health examinations, and a well-balanced diet. Its hereditary transmissibility furnishes a dramatic and encouraging illustration of how disease can be reduced through eugenic planning and of the application of the Mendelian laws to the human race.

Cases and "suspected cases" of tuberculosis. As soon as tuberculosis is definitely diagnosed and reported to the health department, it becomes the responsibility of that department and usually ceases to be a problem in the school. The nurse, of course, continues to be concerned with the individual.⁽²⁹⁾ She may participate in making arrangements for the best possible treatment for him and in arranging for health supervision of the other members of his family. In the case of an employee (and it is an employee much more often than it is a pupil) she may assist in social and economic arrangements for his family as well. In the case of a pupil the nurse keeps in touch with his progress and is ready to help make educational plans for him as soon as this is indicated.

From the viewpoint of the school administration and the school health service, the more difficult situation occurs when there is a suspected case which is not diagnosed.⁽³⁰⁾ It may be that school personnel have observed signs and symptoms of the disease. In another type of situation, a rumor arising from an unidentified source "accuses" a pupil or school employee of having the disease. The desired procedure is to refer the individual to a tuberculosis service for study, diagnosis, and recommendations. The next step

including frequent examinations with urinalysis and blood determinations. Complete cooperation is given physicians of these children in relation to medications that may be desirable in school. Special efforts are made to see that they have the benefit of all possible protective measures for increasing natural resistance to infections, acute and chronic.

Regular exercise, and plenty of it, is very important. The diabetic child's physical education program and participation in extracurricular activities are arranged under his personal physician's instruction. Any adjustments in his school program which are recommended by his physician are made promptly. His own physician and the health service staff combine their efforts to keep his health at the highest possible level and to avoid contact with communicable disease. There is particular need for prompt removal of any source of infection, immediate care of any injuries—especially of the extremities, and avoidance of fatigue, nervous strain, and anger.

The child's teacher is informed of the symptoms of hypoglycemia and hyperglycemia and of the simple first-aid measures indicated. His greater susceptibility to minor infections is kept in mind by both teacher and nurse whenever he has any type of accident.

Fortunately, there is no social stigma associated with this disease. Characteristically the diabetic child is mentally precocious and taller and heavier than the average child. The main educational program is with the child himself, his scientific understanding of his own physiology, the treatment of the disease, food values, his responsibility for his own health and actually for his own life. Even when no food is eaten in school, opportunities are sought to help him understand and adjust to his need for diet restrictions or medication. If he does eat in school, diet breaking is not considered a moral issue. But while other children may be allowed to skip a meal now and then, every precaution must be taken to prevent the diabetic from doing so. Omission of a meal may result in an insulin reaction since the amount of insulin given is related to the amount of food he is expected to eat.

The American Diabetes Association is an organization of physicians with headquarters at 11 West 42nd Street, New York 18, New

disease, his physician may request home instruction. Education is also provided for these children in hospitals, convalescent homes, and foster homes. This education is valuable not only to avoid loss of time for him but because of its value to his morale.

The nurse may be particularly valuable to this child in helping him accept his limitations, by giving him a better understanding of the present concept of tuberculosis and by assisting him in developing new interests consistent with a mode of living and work desirable for him. When an arrested case is fourteen years old, he may be reported to the State Rehabilitation Service for vocational counseling and guidance in planning his high school work.

Syphilis, gonorrhea, and other venereal diseases. What the attitude and procedure of school authorities shall be in dealing with children infected with these diseases is a perplexing problem, but fortunately such cases are comparatively rare. General communicable disease regulations govern the control of syphilis. Except for congenital syphilis, children rarely become infected with this disease in the home. More rarely do they secondarily affect others in school. But since most schools refuse to face this problem when it does appear, a heavier responsibility may be placed on the nurse than is the case with other communicable diseases.

It is estimated that in the United States, there are 100,000 children suffering from congenital syphilis. A large proportion of those who remain undiscovered and therefore untreated may end up in hospitals or in need of medical care and of services for the handicapped. If unable to maintain themselves, they will require institutional maintenance or relief for unemployables.⁽³²⁾

Half of the 150,000 new cases of acquired syphilis each year go unrecognized and untreated. An unknown proportion of them are in our schools, some pupils and some school employees. There are few opportunities for the nurse to find these cases without the cooperation of the person concerned. In direct proportion to the reliance students and employees feel in her professional judgment, her objectivity and her personal ability to keep a confidence are the opportunities for her to help discover and get such cases under treatment.

Extreme caution must be used in any attempt to secure an

$$\frac{d}{dt} \left(\int_{\Omega} u^2 dx + \int_{\Gamma} u^2 dS \right) = -2 \int_{\Omega} u \Delta u dx - 2 \int_{\Gamma} u \nabla_n u dS$$

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1. 本會為維護會員權益，特訂定本會章程，凡加入本會者，均應遵守。
 2. 本會之宗旨，在於促進會員間之交流與合作，共同發展。
 3. 本會之組織，由會員大會、理事會及監事會組成。
 4. 本會之經費，由會員繳納會費及接受社會捐助。
 5. 本會之活動，應以促進會員利益為原則。
 6. 本會之決議，應經會員大會通過。
 7. 本會之修改章程，應經會員大會三分之二以上多數通過。
 8. 本會之解散，應經會員大會三分之二以上多數通過。
 9. 本會之其他事項，應依本會章程之規定辦理。
 10. 本會之成立，旨在為會員提供一個良好之交流平台。

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$$f_{\text{eff}} = 2 \times 10^{-4} \text{ s}^{-1} \quad \text{for } \text{Mg}^{2+} \text{ and } \text{Ca}^{2+} \text{ in } \text{H}_2\text{O} \quad \text{and } \text{Mg}^{2+} \text{ in } \text{D}_2\text{O} \quad \text{at } 25^\circ\text{C}$$

ringworms of other parts of the body than the scalp and feet seemed to appear less often.

Properly handled, such epidemics need no longer cripple a school's attendance or make children miserable. Recent medical advances in diagnostic aids and in methods of treatment, which are much more effective as well as simpler and pleasanter to use, make this possible. There must be teachers who are immediately sensitive to first indications of the presence of such infections, administrators who give priority to activities involved in instigating control measures, and adequate nursing service available to make necessary parent contacts and to screen groups with children known or suspected to have the infections. In the cases, fortunately rare, where parents refuse or neglect to obtain proper treatment, one additional step is essential: School authorities must realize that such neglect is a symptom of a lack of understanding of hygienic living, or lack of concern for the child's comfort and well-being, or indifference to parental responsibility, any one of which threatens the child's safety and happiness in other respects as well. As a result of such a realization school authorities approve referral of these families to the attention of the staff of the children's court judge. After the nurse has made enough home calls to know that the family understands what is needed (or has insufficient intelligence ever to understand) and that necessary materials or medical service are available to them, there is no value either to family or school in having her make repeated visits.

To obtain quickest and most effective control of such threatened epidemics, joint planning and action of school administrator, teacher, school physician, and nurse are involved. The administrator gets in immediate touch with the nurse and, except in the case of pediculosis, with the school physician. The nurse screens the groups concerned. The physician inspects those referred by the nurse. If the number of families in which positive cases are found is small enough to permit it, the nurse makes immediate home calls. This gives her an opportunity to approach the matter in such a way that, if possible, the usual antagonistic reaction of the parent to this sort of news is avoided. She can also assure herself that

examination in those cases where there is only a suspicion of venereal disease. Unless the case is one where criminal action is involved and the case is already under the jurisdiction of the court, a pelvic examination should be made only by the personal physician. An intensive study of a pupil will often reveal symptoms such as nervous tension, headaches, or digestive upsets, justifying referral of the child to the family physician. An informal conference with him before the patient's visit will give an opportunity to explain the situation to him. A request can be made of him to tell the nurse if there is no foundation for the report so that the information can be used to protect the pupil's reputation. If there are positive findings, the nurse does not wish to be informed, as the family physician is expected to treat the disease and make required reports to the health department. From the viewpoint of transmitting the disease to others, a pupil or an employee under adequate treatment should not need to be excluded from school.⁽²⁸⁾

A diagnosis of venereal disease should not be recorded upon the pupil's health record card.

As an educator and as a community citizen, there are many activities into which the nurse can enter with other open-minded and concerned citizens to improve public knowledge, policies, and attitudes on these diseases. She will stimulate interest of lay people in and encourage their support of the program of the American Social Hygiene Association whose headquarters are at 1790 Broadway, New York 19, N. Y. She will utilize the scientifically sound and attractively prepared materials—movies, slide films, and pamphlets—designed on different interest levels for various groups—nurses, parents, teachers, and pupils. Its public information service will answer her questions on such subjects as community organization for social hygiene and education for family life.

Infections of skin and scalp. In the years preceding World War II, these nuisance conditions were steadily diminishing as a problem for school authorities. Then population dislocations, overcrowded and poor housing conditions, and reduced parental supervision combined to send more children to school with head lice, ringworm of the scalp, foot infections, and scabies. Impetigo and

First lines of defense against such danger are teachers expert in detecting suspicious signs and sufficient medical and nursing service to follow up promptly all pupils referred, and to give more professional inspection to all groups involved.

Infection through utensils. A second, lesser danger is through contact with common articles. Hygienic drinking fountains, proper dishwashing, clean toilets properly used, pupils properly instructed and supervised in their use of common classroom materials, and arrangements for care of clothing—as are required for decent community living—are sufficient protection against infections through common articles. However, special supervision of facilities involving bare feet seems indicated. Even here hygiene of the feet may play a more important part than sanitary control of the environment in preventing the large group of infections of the skin of the feet popularly and unscientifically grouped under the term “athlete’s foot.”

In her follow-up of conditions of the feet, the nurse keeps in mind that there are many variations, caused by many types of germs and requiring different treatments. Medications effective for one type may actually increase the difficulty in another instance. School treatment is not permissible except as ordered in individual cases by the pupil’s personal physician.

General instruction concerning hygienic care of the feet can well be emphasized by the nurse, however, in dealing with these cases: keeping feet clean and dry with special attention to the skin between the toes, airing shoes and socks when not in use, frequent washing of socks, elevation of feet when at rest if there is a tendency to rubbing or chafing, light and well-aerated shoes when possible, and use of powder every night and morning on the feet, especially between the toes. Properly fitted footwear is important.

Poisoning from vegetation. When poisoning from ivy, oak, or sumac occurs, the nurse encourages not only those poisoned but all pupils to hunt for sources. The health council or a health class may develop a school-community project for eradication.

Malocclusion and plastic surgery. In no other group of handicapped children are so many of them deprived of treatment for the

the parent understands the need for prompt medical attention and can obtain it, or in the case of pediculosis understands the proper methods of treatment and has or can obtain necessary materials. It is important, too, that she can figure out with the parent the earliest date at which the child can return to school.

When acquaintance with the family indicates that a telephone call will answer the purpose without a home call, this timesaver is used. A note taken home by the child is a last resort and a poor one in this type of situation where emotional reactions can be expected. If a note must be used an individual one is less offensive than a form letter.

Schools find a "loan closet," including treatment materials which can be loaned for care of pediculosis, reduces the time required to get the child back in school. The expense of supplying such materials is slight compared to attendance time saved.

The steel "fine combs" and numerous effective delousing preparations now on the market make it inexcusable for a school either to tolerate vermin or to subject children to the disgrace, danger, discomfort, and prolonged absences involved when parents attempt to control infestations through the use of such an outmoded material as kerosene.

There is an objection here as in other instances to the school recommending any specified commercial preparation. It is unnecessary, too, as so many manufacturing companies have developed satisfactory solutions or powders that the choice of the local druggist can be followed. Since the steel combs are quite expensive and can be sterilized easily and satisfactorily, the school can well purchase some to lend as an emergency measure.

Since such infectious conditions are primarily home problems, school treatment is ineffective as well as humiliating to the child and contrary to good school policy except in unusual situations. For additional discussion of these problems see Chapter 12.

Parents on their part have a right to expect that their children will be given every protection against contracting such conditions in school. While in school the child's greatest source of danger, in these as in most communicable diseases, is from his fellow pupils.

prolonged use of pacifiers, nursing bottles, and thumb sucking and of any sleeping habit which causes pressure against the developing dental arch, such as that of keeping the closed fist between the face and the pillow, will prevent malformations difficult to correct later.⁽³³⁾

The nurse gives individual attention to any cases of birthmarks, scars, or malformations which seem to offer present or potential difficulties to the child's social adjustment or in obtaining employment as an adult. The earlier that correction or even a degree of improvement can be obtained, the less is the danger of damage to the child's personality.

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one reason of lack of money. Since all cannot be treated, the nurse's first problem may be to secure the specialist's examination which will determine whether the case involves more than a minor aesthetic defect, and if so, whether it is amenable to treatment. Characteristically, the child is anxious for treatment, but in a surprisingly large proportion of instances, the parent is hard to convince of the necessity for it. The next, securing the money for it is apt to be difficult whether the family, public funds, or private charity is to pay.

Neglect of needed treatment may result in such physical difficulties as digestive and nutritional disorders, chronically inflamed gums, inability to speak clearly, and greater susceptibility to sinus infections. These are all serious, but there are many instances in which the effects upon the mental well-being and social adjustment of the individuals are even more disastrous.⁽²⁴⁾

Though all 48 states now recognize cleft palates as "crippling" defects, only 28 of them give even a limited amount of aid for the care of such children. Only one state, New York, gives aid for treatment of orthodontial cases not involving cleft palate, and it on a most inadequate scale. Intensive efforts to secure treatment for a few of the most extreme cases will contribute to the general education of teachers and parents in recognition of the seriousness of these conditions and lay the groundwork for the preventive program which is the only real solution of the problem.

Preventive measures include preservation of the first teeth, or if they are lost before they should be, use of space fillers may be desirable if functional dental restorations are not indicated. This preventive work is not only much less expensive than corrective work later but it is within the province of the general dental practitioner and therefore not affected by the lack of specialized orthodontists. Breast feeding does more to develop the child's face and jaw muscles and the pressure of the mother's breast against the anterior of the jaws is beneficial in preventing the crowding of teeth which occurs in underdeveloped jaws. Correction of conditions causing mouth breathing, before the habit has become fixed is another definite measure of prevention. Correction of habits of

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PART IV

*The Nurse's Part in General
Health Supervision
and Education*

Day-by-day Health Supervision of Pupils and School Personnel

Parent, teacher, and nurse. The nurse's own supervision of the child is but one aspect, and not the most important one, of her responsibility for his day-by-day health supervision. Parents, of course, play a vastly more important role than does the nurse; the classroom teacher has even more opportunity and greater responsibility to function effectively. The child himself as he matures must be assisted to develop increased competency in self-supervision.

The nurse's greater contribution then is her assistance to teacher, parent, and child in developing these abilities. She helps them establish a good standard for what is normal, a sensitivity to variations from the normal, and a proper attitude toward these variations, avoiding the extremes of hysterical anxiety and of indifference. Through the nurse's participation in day-by-day supervision, she finds the best opportunity for such teaching. Lectures to groups, telling them what to look for, how to react to what they find, and what to do about their findings are helpful but much less productive than living through the various situations with the individual. Guiding their understanding of and their emotional reactions to the problems that arise, and helping them make proper plans to care for the conditions discovered, do more to prepare them to meet

future situations without the nurse than is possible through verbal instruction alone.

As teacher and nurse work together, frequent reference to such a publication as *What Every Teacher Should Know about the Physical Conditions of Her Pupils* ⁽¹⁾ will help prepare the teacher to meet her problems when the nurse is not present. With parents, for a similar purpose, the nurse uses such publications as *Your Child from 6 to 12* ⁽²⁾ and *Child Care Questions and Answers*, compiled and answered by the Children's Welfare Federation of New York City. ⁽³⁾

Strengthening out-of-school supervision. Certain fundamentals teacher and nurse together emphasize to the parent as basic to successful over-all health supervision of all children. One is to have a pediatrician or family physician see the child at stated intervals in his growing years. The best school health service imaginable cannot compensate for lack of this type of supervision. As in other areas of the child's education what he receives from the home contributes to the success of his education by the school, and what he receives from the school helps the home in its management of him. Besides convincing parents of the necessity for medical supervision, the community must be led to provide health supervision facilities for those children whose parents are unable to do so. Even in communities where adequate provision has been made for supervision prenatally and for the first year of the child's life, there is often a lack of such service for preschool and school age children. Physicians' examinations are vital, as possible defects are discovered much earlier by a physician. He may find them before they cause symptoms obvious to those less well trained. More important, the child and his parents are given early and constructive suggestions concerning growth and development. This is an actual "health" service, not just merely a remedial one after damage has been done.

Utilization by the school health service of the suggestions from the family or health clinic physician is something which must be definitely planned as it will not happen without effort. When possible, methods for exchange of information are arranged with the local medical society as a group. If this is not possible, they must

be developed by each physician individually. A two-way exchange of pertinent information is put in operation, as the school and the private practitioner see the child from different angles and both accumulate information about him. For instance, physician, home, and school need pooled information if effective plans are to be made to limit young Charlie's extracurricular activities to those which will ease his exaggerated nervous strain during school hours.

As a second activity of out-of-school health supervision, parents are encouraged to keep health records of their children, an extension of the present "baby book" idea. At the present time there are few real health records of children beyond their infant years, except those kept in schools. Those kept by family physicians and sometimes even those in the offices or clinics of pediatricians may be restricted to an account of the child's ailments rather than his normal growth and development. Of the small proportion who attend offices or clinics where health records are kept, only children whose families (or physicians) do not move about while they are growing up enjoy the advantages of continuous records. Without them, and a year-by-year careful study of his bodily needs during periods of rapid growth, sympathetic adjustment of his school work to those needs is hampered.

Transfer of health history. Until national and state health agencies and medical societies set up forms for such histories and stimulate their use and transfer, the schools must carry the responsibility for accumulating, preserving, and transferring from one school to another, the invaluable data needed to understand and properly supervise the child. Since it is already established that scholastic records must be so transferred, it seems an unnecessary waste that health records are not more generally transferred also. No school health record should be given to a child or his parent. A simple transfer statement of the child's grade with identification of the school from which he comes is sufficient to carry over until the new school can write to the old one for the records. Although the family may know the city to which it is moving, it will probably not know what school the child will attend because the present-day complexity of school administrative set-ups and lack of coincidence of school

district and city or village lines are confusing. Therefore, it is considered better to put the responsibility on the admitting school to send for the record rather than have the school the child is leaving attempt to send it without waiting for verification as to his new school. As studies and information concerning his scholastic progress and physical and personality development become more adequate and meaningful, the confidentiality, preservation, and safe transfer of all records is magnified in importance. (See Chapter 14.)

Education for health supervision in later life. Those children fortunate enough to grow up under a regimen including a positive health supervision which really functions, in and out of school, are much more apt to become adults who will continue to seek professional guidance. They will thus profit by the best protection of which we now have knowledge against the chronic and degenerative diseases of middle and old age. These are outstanding among the unsolved public health problems. The individual, who as a child has absorbed a positive attitude toward health, will be protected against the unreasoning fear of illness and possible pain which makes so many adults postpone needed medical examination and treatment until it is too late.

Nurse, parent, physician, and teacher combination. We know parents and school personnel must learn to work more closely together than is yet the case in many schools if the child's best interests are to be served. The combination of nurse, parent, family physician, and teacher focused on the concrete processes of providing an effective health supervision for the child, in school and out, by setting up a practical pattern of united action, may be taking a vital step in achieving an ability for a close working together in other less tangible and more difficult areas.

Without honest, accurate, and prompt exchange of information between school and parent, neither can give the child the help and understanding he merits. Such exchange in the past has too often been confined to problem situations. A constant stream of transfer of information is essential if proper guidance for normal growth and development as well as for managing crises is to be furnished. The adults concerned with the child must have learned to talk

together easily and frankly; they must trust one another and must be able to learn from each other. In some instances the nurse may actually bring the parent and teacher together. In all cases she promotes the idea of such an exchange and concrete plans for bringing it about.

The expectation of sharing information—knowing that someone else is interested—provides added incentive to teacher and parent in acquiring it and increased care in being sure it is accurate. The nurse can help them by increasing their sensitivity to variations from normal, by pointing out illustrations as they occur, and explaining possible implications. Besides helping them sharpen their use of eyes, ears, and sense of smell, the nurse can see that they learn to read a clinical thermometer accurately. At least in the case of the teacher she can see that a thermometer is available for her use.

After teacher and parent have learned to react to all the small signs that a child may be ill, uncomfortable, or unduly tired, the next step is to increase their perception as to the possible cause. Is it due to lack of sleep, improper food, eyestrain, poor hearing, uncleanness, a lack of regularity of living, lack of emotional security, or what? Of course, the final diagnosis is not necessarily left to parent, teacher, or nurse. But in many instances the cause is there for any observant person to see and the sooner it is detected, the better for the child. Even in cases where help in determining the cause is required, the physician, psychiatrist, or other specialist must rely upon those who are closer to the child than is he for much of the data upon which he will base his judgment.

Review of growth record. A healthy child grows continuously. Weighing at regular intervals furnishes concrete evidence of successful or unsuccessful growth and development and acts as a motive for securing treatment of defects and following a healthful regimen from day to day.

Such data furnish the health service staff as well as the teacher with information invaluable for health supervision.

For school weighing a balance scale is most desirable; spring scales are unsatisfactory. Scales should be checked by the local or

attendance, immediately after her nursing office hours. The review is more meaningful if the reports show how long the pupil has been absent and the reason if known. Sometimes the teacher indicates that she feels a nursing or attendance visit is needed.

Parental responsibility in reporting illness absences. The number of unnecessary home and telephone calls can be reduced if parents are urged to report the nature of illness of their children on the first day, either by telephone or a written or verbal message through another child or the bus driver.

The school assumes the parent wants the child in school if he can be and that the child knows the school wants him there. A special effort may be needed to make parent and child understand also that the school does not want him there when he should not be. Former emphasis on readmission examinations is now placed on referrals for exclusion examinations and on follow-up of exclusions.

Many parents welcome help from the school in learning to know when they should keep children at home. This assistance may be given in a form letter which includes such information as the common symptoms of communicable disease, periods of incubation and communicability, and so on and points out the seriousness of the common cold. Some schools prefer to notify parents directly as soon as a communicable disease occurs in the community or school, and advise them what should be done relative to the specific condition. Other schools make good use of the local newspaper to give parents needed information. All letters or newspaper articles should be simple, nontechnical, and as unalarming as possible.

Responsibility of school employees for reporting illness conditions in self or household. Instruction from the school physician at stated intervals, usually annually, helps employees learn to meet and, even more important, to appreciate the importance of meeting this essential responsibility. The major value is protection of the pupils and other school personnel; a secondary, but sometimes vital, function served by such reporting followed by proper action is avoidance of situations which might result in bad public relations with the parents if improperly handled. The physician may supplement this basic instruction with additional specific information

when the presence or threat of a certain disease indicates the need. Such information may be given in specially called meetings or through mimeographed notes. Employees should receive copies of any materials sent parents on communicable diseases, both for personal guidance and in order that they, as school staff, may help educate the general public as they participate in informal discussions in the community.

The physicians' best efforts may be ineffective unless reinforced by the administrator. His personal practice in following or ignoring the policies laid down sets a good or poor pattern. He encourages prompt and frank reporting if he deals with the situations resulting from reporting by employees in such a way so as to minimize as much as possible any resulting hardship to the individual.

It is often unnecessary for the nurse to take any formal part in the procedures involved, as these may be handled between the administration office and school and family physician. Always, however, her influence may be valuable in building up an attitude in the group that puts protection of pupils above the convenience of school management or selfish personal interests of school staff.

Nurse and readmission of pupils returning from absences. The nurse, when available and especially if she is the attendance supervisor, is the logical member of the school staff to readmit illness absentees. She reviews the excuse brought by the pupil and the release from the health officer or physician, when this is offered. She also inspects the pupil, taking temperature, looking at throat, eyes, skin (for rashes or sores), and determines whether the pupil seems ready to resume his usual school program or needs some modification of program for a few days. There are instances when it is necessary to send a pupil home and recommend re-exclusion, because the condition for which the pupil was out of school has not cleared up. The assumption is that it may have changed for the worse since the child was last seen by his physician or the health officer.

Interviews by nurse with school employees returning from illness absences. These are customarily limited to those individuals who were not under medical supervision while absent. The nurse

usually takes no part in the recording of absences or causes. Her function is to advise the individual if further absence seems desirable or if medical care should be sought, and to make appropriate recommendations to the administrator or school physician.

Recording illness absences. Before returning the pupil to his classroom, the nurse should affix to the pupil's excuse, attendance card, or referral slip, the proper code number for the illness absence. A practical code is:

Code No.	Conditions Causing Illness Absences	Code No.	Conditions Causing Illness Absences
1	Common cold	16	Measles
2	Other respiratory illness (except 17)—cough, influenza, bronchitis, etc.	17	Pneumonia
3	Sore throat, tonsillitis	18	Poliomyelitis (infantile paralysis)
4	Stomach and intestinal disorders (digestive upset)	19	Scarlet fever
5	Headache	20	Vincent's angina
6	Toothache	21	Whooping cough
7	Earache	22	Mumps
8	Eyes (except 23 and 29)	23	Acute conjunctivitis (pink-eye)
9	Accident, infection, or emergency operation	24	Impetigo contagiosa
10	Menstrual difficulty	25	Ringworm
11	Nervous disturbance (emotional upset)	26	Scabies (itch)
12	Illness—specific cause unknown	27	Pediculosis capitis (lice)
13	Chickenpox	28	Any other (specify)
14	Diphtheria	29	Absence for preventive or corrective health measures (examination, treatment, operation)
15	German measles	30	Quarantine or isolation (but not ill)

It becomes the responsibility of the classroom teacher to enter the code number with the illness symbol (S) in the attendance register. When this is done it is comparatively simple to analyze the causes of absence or to summarize them for the pupil's health record. To be of value, all illness absences, whether or not checked on admission by the nurse, are coded in the register.

other 19 per cent were due to such causes as parental neglect and the child's help being needed at home.

Classification of illness absences and readmission procedures.

Illness absences are divided into five major groups, and the readmission procedure for each is as follows:

1. Absence due to reportable communicable diseases:
 - a. Minimum length of absence is determined by State Sanitary Code or local community or school regulations.
 - b. Case must have official release from quarantine or isolation from health officer.
 - c. Case should be seen immediately prior to return to school by family physician or by school physician if there is no family physician.
 - d. The nurse should inspect pupil on his return to school and readmit him unless there have been developments which make it necessary for the school physician to pass on pupil's condition.
 - e. Regardless of condition of pupil in reference to communicable disease or any severe illness, the school administrator must be assured that pupil is in such physical condition that he may safely undertake the school program.
 - f. The nurse watches for any evidence of recurring symptoms or complications.
2. Absence due to nonreportable communicable diseases:
 - a. Length of absence is determined by the condition of the pupil and by evidence of communicability.
 - b. Child requires inspection and opinion of family or school physician (school may require a written statement from physician when deemed necessary).
 - c. The nurse should see on return all pupils who have had a non-reportable communicable condition and should consult school physician in any questionable case.
 - d. The nurse watches for recurrence.
3. Absence due to quarantine or isolation:
 - a. Even though pupil has not been ill, the statement of the health officer is needed for readmission.
4. Absence due to general illness, operations, or injuries, etc.:
 - a. Condition of pupil determines length of absence.
 - b. A written statement from family physician is desirable and may be required if school authorities are not satisfied with excuse given by parent.

- c. The nurse should inspect pupil on return to school and readmit him unless there have been developments which make it necessary for school physician to pass on pupil's condition.
- d. Regardless of condition of pupil in reference to communicable disease or any severe illness, the school administrator must be assured that pupil is in such a physical condition that he may safely undertake the school program.
5. When a pupil has been absent for remedial or preventive health measures, a statement from physician, specialist, or dentist giving the treatment is desirable and may be requested.

The nurse, whether or not she is also the attendance supervisor, is concerned in maintaining a high standard of daily attendance. The first interest of the nurse is in the quality of attendance which eventually results also in better attendance in terms of numbers.

The nurse and teacher who cooperate in the early exclusion of pupils with colds or symptoms suspicious of communicable disease find that the average daily attendance for that grade is generally better than where sick pupils are allowed to remain in school and infect others. Early exclusion of the case, follow-up and exclusion of contacts, cooperation of parents in keeping sick or apparently sick children at home and informing the school, and calls to see that parents have necessary information about isolation and treatment are the best assurance of a high standard of school attendance. (See Chapter 13.)

Assisting teacher in her classroom inspections. For the teacher's responsibilities in inspecting pupils see *What Every Teacher Should Know about the Physical Condition of Her Pupils.*¹⁷⁾ The less association between pupils before health inspection takes place, the more effective the inspection. Therefore no one individual, such as the nurse, can inspect more than two or three groups at the most and have inspection occur early enough to assure proper protection. The highest type of morning health inspection occurs as each child on his entrance goes to the teacher to say good morning and the teacher has sufficient experience, alertness, and interest to detect in an apparently casual glance any deviation from the desirable or normal.

Opening inspections. *Health in Schools* ⁽⁸⁾ includes the statement that "whenever the schools are reopened after being closed for more than a few days, it is desirable to make a comprehensive inspection of all children on the first day of the newly opened session. This may be done by nurses or teachers who will refer suspected cases to a physician."

Eventually children and parents may learn to give such a good inspection in the home that the one at school becomes unnecessary. If pupils fail to meet proper standards of preparation for school they need instruction as to certain details upon which they should check at home before considering themselves ready for school. In many cases it is desirable for the nurse to make a home call to discuss these standards with the parents. Only those things absolutely within the child's own control are taken up with him in school. For example, no comment on his clothing is made to the child unless it is first established through information from the home that it is entirely through his own indifference that he is not properly dressed.

Daily inspection is carried on by teachers but the nurse can be of valuable service to them by helping them develop their powers of observation and their ability to interpret the variations observed. The following is quoted from *Training of Elementary Teachers for School Health Work*: ⁽⁹⁾

. . . it has been pointed out that . . . the central active figure in the finding and removing of sources of infection was the classroom teacher. In the daily observation of her children the teacher, placed in the position of the parent, is the only person who can at once note changes indicative of an invasion by lice or the onset of measles, mumps, etc. It is not her business to know what an ailment should be labeled, but she can note symptoms which indicate that the organism is out of balance (out of health). The signs and symptoms of communicable diseases are so simple as to make the preparation of the teacher for this function (an ability parents are supposed to have without training) an easy one.

It has long been recognized that the child with poor vision or poor hearing cannot be expected to do his school work with the ease and accuracy of one with normal senses, and long ago some teachers had the

common sense to note the presence of such pupils and to place them at points of vantage for best sight and hearing. And yet, after hundreds of years of educational work, we find many teachers who are so intent on obtaining certain results that they forget the tools with which these results can be obtained. . . .

. . . [The teacher] . . . should have a knowledge of the fundamental facts about the diseases which frequent the schoolroom and of how they are transmitted, but for purposes of eradicating these diseases the teacher need not know measles from mumps for the first symptoms may be the same. It is his business to recognize the deviations from normal that indicate that something is wrong. The mischief of transmitting the infection is likely to occur before anyone is able to label the condition. . . .

. . . Skin diseases are difficult to recognize from mere description, and keenness of diagnosis is not to be expected from classroom instruction; but any teacher can learn that clean hair is free from nits, that normal scalps do not present patches of scales or stubble, that healthy heads are not usually scratched by their owners, and that there is something wrong when a previously clear skin exhibits an eruption.

Some of the recent prints in colors representing the more usual signs of the skin disease frequently found in the schoolroom (such as impetigo and ringworm) may be of some help in sensitizing the teacher to such conditions. . . .

Although the nurse can do much to increase the effectiveness of morning inspection in a school system, the responsibility for planning and carrying out an effective program remains with the superintendent or principal. Satisfactory results are not obtained without a definite plan which provides for participation of principals, teachers, pupils, and parents. Every nurse of experience knows of certain teachers whose attention to their children is so keen that any variation from normal is immediately detected. In such rooms it is unnecessary for the nurse to make a routine classroom inspection at stated intervals. When the nurse finds that repeated inspections do not reveal conditions previously not reported by the teacher, she is justified in omitting that room from her schedule of inspections and concentrating on rooms of less experienced and less observant teachers. The nurse or teacher refrains from touching or handling

children unless she can wash her hands before touching another child. This is for her own protection and to avoid any possibility of spreading infection from child to child. It is also a teaching demonstration.

Special classroom inspections by the nurse. When a communicable disease is present or threatens, and in certain groups in some schools after each vacation, the nurse makes complete and careful classroom inspections of all children, beginning with younger children and with schools where children come from homes with less desirable standards of cleanliness and child care. The teacher is at her side while this is being done but no comments are made in the presence of children except those of a positive and commendatory nature. The occasion should be pleasant and interesting. With a little practice and effort the nurse can develop ability to observe and comment affirmatively on something about even the least attractive child. Unless care is used it is possible to make inspection both a disagreeable experience for the child and an occasion resulting in a reverse of health teaching, that is, the setting up of undesirable mental attitudes of the child toward his health. If children as a group are taught a simple routine that supplies a fair amount of physical activity for them, if comments are all positive, and if all children apparently receive the same amount of attention, with a matter-of-fact atmosphere prevailing, most of the danger can be averted.

Development of group participation in inspection procedure. All extra wraps should be removed, sleeves rolled up, and collars unfastened. Generally it will not be necessary for boys to remove their ties as unfastening the buttons underneath the tie is sufficient. The nurse (or teacher) should explain that she wants to see "how well you look after your vacations," that she wants to be sure to notice everything about everyone—hands, eyes, nose, mouth, teeth, tongue, and throat. So that she will not overlook some item, they "all must help by showing each of these things." With the children in their seats, they may well practice the routine together. This procedure saves a great deal of time and energy and also pro-

duces a desirable mental effect, for if the whole program is followed by the children as mechanically as possible, it soon loses much of its unnatural significance to them.

First they show their hands with fingers spread apart and palms up, and then they turn them over to show the backs. Since this routine is being established also for use when a communicable disease may be prevalent it is well to consider the protection of the inspector on such occasions. Therefore to ensure a safe distance between inspector and children, they are instructed to throw their hands forward. They enjoy this better than a more passive movement. Presence of rashes, sores, and malformations are noted. Special attention is given to surfaces between fingers and on the inside of arms.

Next, with their elbows on the desk, they place their two forefingers together in a pyramid or tent. Turning the head sidewise, they run the apex of this pyramid up behind the ear into the thick hair above the ear. This action not only parts the hair but lifts it from the ear, giving the inspector an opportunity to observe any discharge from the ear, any skin infection around it, any redness or swelling over the mastoid bone, any abnormality of the glands on that side of the neck, and the condition of the scalp in that portion where pediculosis, if present, is most easily observed.

This same action is repeated for the opposite ear. The neck is observed for presence of enlarged glands or rash.

Again elbows are placed on the desk. This time the two forefingers are placed parallel to the desk, then gently on lower lids of the eyes and the lids are gently and slowly pulled down a very little way. (Too often when one wishes to observe the mucous membrane lining of the lid the child pulls the lid down in a painful manner, with a straining motion.) In this position the inspector can observe the color of the mucous membrane, any granulations of lids, inflammations, sties or redness and crusting, the condition of the eyeball for opacities or scars, squint, cross-eyes, and general brightness of the eye.

Next the child is instructed to smile with his teeth together. A broad smile should be cultivated so that even the lower gum margin

may be observed. Then the mouth is opened, in a natural manner, giving opportunity for observation of the surface of the tongue and condition of the molars. The nostrils also should be observed for crusts, evidence of blood, discharge, or any obstruction.

Next the tongue is protruded as far as possible, the ambition being to have it "touch the bottom of the chin." Then a very deep breath is taken and held while a strenuous "a-a-a-h-h" is pronounced. With some children a suggestion that they yawn gives the desired view of throat, teeth, gums, tongue, tonsils, and pharyngeal tissues. Instruction to "pant like a dog" gives a similar view. If patience is used in training the child to open his mouth properly no tongue depressor needs to be used to make adequate inspection of the throat. If its use can be omitted it means that from beginning to end of the inspection, the child has nothing "done to him." It is not only good hygiene for the inspector to avoid handling children but also it is much more desirable from a mental hygiene point of view.

Completing the procedure, the child with his right hand may pull the front of his blouse away from his body as he bends forward, then with his left hand, pull the back of it out as he bends backward.

The group should practice this routine several times all together; then it may become a game to see if they can remember it all as they stand in front of the nurse, who is in one corner of the room with her back to the light.

Discontinuance of formal classroom inspections. The use of this routine is kept to a minimum. As long as the teacher's informal individual inspection, made as pupils first enter her room, is adequate for the situation the routine is not used. It is only when large numbers must be checked frequently, because of some communicable disease (or because of the failure of the teacher to handle inspection in the more desirable way) that this method is used at all.

Inspection for adjustment of seats to pupils. The nurse trains herself so that each time she visits a classroom she reacts automatically to any of the various indications that a pupil's seating arrangement is improper for him. He may outgrow before January an arrangement that fitted him in September.

The teacher may wish the nurse to assist her in checking sitting positions when a new group of pupils has been assigned to her classroom. If each child has an individual movable seat and desk (which is preferable to one screwed to the floor) it is checked as to proper height of chair and desk. They are adjusted so that each child may sit and work in comfort. The seat should be of such height that the child can sit with feet flat on the floor without pressure on the thighs, of such depth that there is no pressure on the legs just below the knees; and so it supports the upper and lower back. Desk or table should be of such height, and so placed in relation to the seat, that the child can rest his forearms upon it comfortably while maintaining correct sitting position. Seats should be placed so as to reduce close contact of children to a minimum. It is desirable that the children take part in adjusting the furniture.

If the unadjustable type is used the nurse helps the administrator and custodian realize the necessity for moving such furniture from room to room in accordance with pupils' needs, and for having a wide variety of sizes in one room if the pupils vary considerably in size.

In her home visits the nurse uses every opportunity to interest parents in proper sitting positions as children study, read, and work at home. (See publications of Nursing Advisory Services for Orthopedics and Poliomyelitis, National League for Nursing.) She instructs parents by demonstration when she can in ways of checking proper sitting posture and shows them adaptations possible with their present furniture. Proper adjustment of the mother's position at her sewing machine offers a teaching opportunity of specific effectiveness if she experiences increased comfort and lessened fatigue as a result of the change.

Sensitivity of the nurse to healthful working conditions for the school staff. She may see teachers and administrators carrying schedules that allow too few breaks for relief of tension, too little time for lunch, and too many extracurricular activities. There may be a lack of rooms in which teachers may relax when not teaching. The one "teachers' room" may have been taken over for pupil activities through the pressure of overcrowding, and too rare is the building

which even in its original plan included a room for the men teachers.

Clerical workers may be found working in any odd corner, improperly lighted, with too much or too little heat, or with no provision for ventilation. They may be using desks and chairs designed for persons much larger or smaller.

The maintenance staff may lack hygienic safeguards which would be legally required in an industrial plant.

While improvement of certain adverse conditions is dependent on building construction, availability of more teachers, new sources of income for educational budgets, and other remedies outside the nurse's province, there are other situations which can be improved if recognized and worked on.

The nurse may have more opportunity than the physician to observe hazards and unhealthful practices. By calling them to his attention and securing incorporation in his report to the board of education of recommendations concerning them, at least one step toward possible improvement has been taken.

There are sometimes modifications of practice the nurse can suggest, and inexpensive improvements in or rearrangements of equipment that will reduce the deleterious effects.

Individual inspection. Most important considerations in making a good individual inspection are that it shall be a private affair, that it shall be pleasant and leisurely enough to secure all helpful information from the child, and that the nurse shall use every means to be sure the child really understands any features involved which he should understand. The more the pupil has a feeling of personal participation in inspection and the less his feeling of "having things done to him," the better. In individual inspection, having him inspect himself in a long mirror and tell the nurse what he finds, is one way of doing this. The nurse will be sensitive to changes in a child's condition or behavior due to a major crisis at home such as a death, birth, serious illness, or loss of job, or from lesser disturbances such as quarrels, relatives visiting, or mild illness especially of the home maker.

In general the nurse will inspect individually four groups of cases—pupils returning after illness absences, those referred by

teachers following classroom inspections, those returning for re-inspection, and those referred by the principal's office as new admissions to school.

Inspection after illness absence. The nurse will have two questions in mind about these readmissions. "Is it to the child's best interest that he be allowed to stay in school?" and "May there be any possible harm to anyone else?" She pays particular attention to eyes and ears and retests vision or hearing when indicated. (See Chapter 9.) If the illness has been a reportable communicable disease, the routine is comparatively simple. She verifies dates of incidence and release by the report from the health officer. If the child was excluded because of suspicion of a communicable disease or because of a nonreportable communicable disease, again it will be a question of diagnosis and release by a physician.

If the illness was other than a communicable disease, the law may require or it may be desirable that the child present a certificate from his family physician or be examined by the school physician. This is valuable both as a guarantee against malingery and as an assurance that the child has had proper medical care. While it takes time to educate the community to the value of such a regulation, when this is done its value soon becomes obvious to all. School officials see the improvement in the protection of children's health and resulting increased attendance. Parents appreciate the protection it gives their children from unsupervised illnesses of other children. Family physicians are afforded the opportunity to give their patients the highest type of care which is possible only when they receive their cases early.

When families are involved whose finances are such that they must rely on the community for medical care, the advantages of such inspection are even more marked. An arrangement then becomes necessary which provides for the service of the school physician or health officer at some stated time during the day for examination of indigent cases before they are allowed to return to school. In some communities this is provided between 4 and 5 o'clock at the close of the working day; in others at an hour-period beginning

half an hour before school opens in the morning. This increased supervision of children too often neglected by parents and community alike has been found to be most effective, especially in cutting down diseases of skin and scalp.

If an effort is made to have the parents and family physicians really understand the purpose of the regulation requiring inspection before readmission, difficulties in enforcing it will be minimized. For example, take the case of a child subject to some recurring illness. After the school is assured that the case is being adequately cared for and that the attitude of the family toward attendance is such that malingery need not be feared, one blanket statement from the physician in charge might easily be accepted to cover all absences from that cause. It is as the representative of the school physician that the nurse reviews these cases, but all questions requiring medical judgment are referred to him for a medical opinion.

Adjusting school program for pupils returning after illness. The nurse works very closely with children who have been absent because of illness. If pupils start in gradually they will be capable of doing more work under better conditions than if they attempt a heavy program (mental or physical) before they have fully recovered. The nurse understands the importance of a modified program for the child who has been ill and she can explain the need to teachers. In many cases after illness absence the pupil may desire and the teachers may give him more work than usual so he can make up what he missed during his absence. Following communicable diseases, while he may have recovered from all acute symptoms, his resistance and stamina are usually below normal. Close or long-concentrated hand- and bookwork are avoided. Strenuous play is curtailed. This may be limited as to length of time for participation or type of activity. If homework is assigned it should be brief and not of an intensive nature; it usually should be limited to a week end.

Physical education and extracurricular activities are apt to need special supervision in junior and senior high school. Lesson assignments and homework present an increased problem in these groups.

too, because teachers are preparing pupils for state or school examinations and are anxious to have them make up all work they have missed.

An illness of even a week or ten days in bed depletes muscle tone and may predispose to contractures. In the course of her home calls, the nurse may help arrange for good bed posture and may encourage activities, according to the child's ability, to make his return to school earlier. She warns parents against allowing children to resume all their usual physical activities on their first day out of bed. Children do not recognize fatigue and need careful parental guidance.

Individual inspection of pupils discovered in classroom inspections. In addition to seeing pupils who have returned after illness absence the nurse will frequently have occasion to make individual inspections of a second group of children. These are pupils who have been found by the nurse or the teacher in the course of classroom inspection to have some evidence of an abnormal condition.

First the nurse makes a complete and thorough inspection of the child. (See Chapter 13.) Until a child has been proved by the nurse's own experience with him to be a malingerer it is advisable for her to give due consideration to any complaints he may make, even though she can observe no objective symptoms. It is much less serious to let a child go home who really does not need to go than to force a child who is really sick to stay in school.

Time is saved and confusion avoided if pupils who are sent to the health room bring with them from the teacher a referral slip, health data folder, cumulative record card, or a simple form with pupil identification (name, grade, and date) and a space for the nurse to make a note of the problem and the disposition. For those who are not sent by a teacher but come directly to the nurse, she may arrange a table with pencils and blanks near the entrance where the older pupil, unless he is too ill, can fill out his own card. For the busy period before and during opening of the morning session an older pupil may be assigned to assist in filling in names and in

keeping waiting pupils in a spaced line (or lines) to avoid close contact.

Reinspection appointments. The third group of cases the nurse will see for individual inspection are those whom she or the physician have seen before and who are to be checked to determine whether they have followed advice given, and if further instructions should be given. In each case the nurse consults her written record of the case and observes and records developments.

Inspection of pupils referred by principal's office as new admissions to school. After getting acquainted with such a pupil the nurse inspects him and reviews his health record, if it has been transferred from his previous school. If it has not yet been received she makes a temporary card for him, and if there seems poor prospect of obtaining his previous record she schedules him for early examination by the physician.

Automatic referral of new admissions to the health service is a protection against introduction of infections and is also a good first step in impressing the pupil and his parent with the school's concern for his health. It ensures against loss of time in securing attention for conditions that might endanger his health or development.

Consideration for pupil's dignity. These individual conferences give the nurse an excellent opportunity to become acquainted with pupils if in speaking to them she calls each by name. This will help her remember them as well as make them feel her personal interest. A general term of endearment is an unsatisfactory substitute. If individual names cannot be used, identification as "first boy," "girl by the window," or some other impersonal indication is preferable to "dearie," "sonny," or "that short boy." Use of a designation based upon a personal characteristic may be humiliating. The nurse who remembers always to treat her children with the respect that is their due is repaid by their increased consideration for her.

Communicable disease information. Health departments of most states provide communicable disease charts which give early

signs and symptoms of the most common communicable diseases. It is essential for every school nurse to have the current copy of this chart. Also it is desirable for the principal and teachers of elementary grades to have copies or easy access to one. If such a chart is not available the school will find it desirable to use the current edition of *The Control of Communicable Disease*.⁽¹⁰⁾

Nurse's responsibility in communicable disease control. The nurse holds a key position in regard to communicable disease control. Much depends on her alertness in recognizing the possible signs of suspected communicable diseases. Her preparation and her familiarity with nursing care for communicable diseases enable her to give valuable advice about exclusions where communicable disease is suspected. She may assist in removing sick children to their homes, and advise parents in regard to isolation of nonimmune family members, especially younger children, and the need for medical or nursing care. She may recommend the exclusion of a school employee, administrator, teacher, or other staff member. All this is particularly significant if there is no school physician present to pass judgment and if there is doubt about availability of the family physician, or health officer.⁽¹¹⁾

In general the nurse follows directions for exclusion and readmission outlined on the official communicable disease chart and sanitary code. It is always desirable to have a physician see the suspected pupil immediately but too frequently this is not possible. Unless a physician is in attendance it becomes the duty of the person in charge of the school, i.e., school administrator or in a one-room school the teacher, to report existence of the suspected communicable disease directly to the health officer. Or this duty may be delegated by the school physician to some member of the health service staff. A definite procedure for notification is worked out by the school physician with the health officer (telephone, post cards, or other means).

After the school authorities have excluded the child or person suspected of having a communicable disease, have safely conveyed him to his home and informed the health officer, further management of the case becomes the legal duty of the parents (in the case

of pupils, or the individual himself in case of school employee), attending physician, and the health officer.

Transportation of sick children. Transportation of sick or injured children is discussed further in Chapter 13. When communicable disease is suspected it is naturally assumed that a public conveyance will not be used and any conveyance that is used should be protected. A large piece of rubberized material which can be hosed and aired later is useful for placing under and around the child.

Care of textbooks, buses, and food handlers. In the chapter on communicable disease control in *Health in Schools* (Twentieth Yearbook of the American Association of School Administrators), school administrators and school personnel will find helpful information about inspection of food handlers, school buses, and care of textbooks when these are affected by existence of communicable disease.

Thermometer sterilization. The technique for thermometer sterilization as outlined in the current edition of the general nursing manual in use in the state or community should be used in the school and in teaching parents in the home.

Closing schools when communicable disease exists. During an epidemic the department of health usually has power to order that the school be closed. It is desirable, however, that school be kept open unless too many pupils are absent to justify continuance of instruction, or illness of teachers and inability to get substitutes makes it impossible. In such a case authority for closing schools rests on the school administrative officers in conjunction with the trustee or trustees. Only in a small school in an isolated situation are pupils protected from exposure by closing the school.

Vaccination and immunization for pupils. Children should be protected against diphtheria and smallpox before entrance into school, generally in the last half of the first year of life, followed by booster doses. If the parents have failed to secure this protection before the child enters school, it is the responsibility of the school to urge education of the parent as to the value of such protection and to advise where it can be secured. A school that does not main-

tain a high percentage of pupils immunized and reimmunized against smallpox and diphtheria has failed in its health education and health protection functions.

If there is a state or local compulsory vaccination law the school and public health officials plan together regarding methods of enforcement.

Classroom immunity list. When a communicable disease occurs in a classroom or bus group in the elementary school the first responsibility of the nurse and teacher is to find the children who are contacts and nonimmunes. The health officer usually takes care of immediate contacts, if known, but the more remote contacts and nonimmunes must be watched by the teacher and nurse until the incubation period for that communicable disease is over. The health record carries information about communicable disease obtained at a time when there was no motive for subterfuge. The increasing popularity of whooping cough and tetanus immunizations makes a listing of pupils so protected desirable.

A classroom immunity list contains names of all pupils in the grade and data as to whether or not each has been immunized. Two methods are used. In one, the lists are made out at the beginning of the terms and all communicable diseases are included. In the other, no list is made up until a communicable disease appears; then the list is prepared for the specific group and the specific disease. The nurse keeps a calendar of immunization in her file for ready reference and in her bag used for home visiting.

Environmental surveys. The nurse may or may not have a responsibility for making formal surveys of the school plant. Always her sensitivity to insanitary or unsafe situations in buildings, grounds, or equipment, as well as undesirable practices such as improper selling of candy and soft drinks, inadequate supervision of food handlers including student help, lack of rest periods, and the like, is one of her greatest values to the school system. Her training and experience enable her to see dangers not obvious to anyone else on the school staff but the physician.

The physician, nurse, and school administrator join in making a comprehensive tour of buildings and grounds as early in the school

Care of School Emergencies

The nurse knows the many things which parents, pupils, and schools can do to reduce the number of sudden illnesses and accidents. She does all she can to get preventive procedures incorporated into their lives as they live them in the school and in their homes. Nevertheless she is not so optimistic that she fails to realize that even the best efforts of all concerned cannot prevent all emergencies—children, human nature, and the elements being what they are. About 40 per cent of all accidents involving children of school age happen on school playgrounds and in school buildings—about half and half in each.⁽¹⁾

Even though good management cannot guarantee to prevent all emergencies, while the child is under its jurisdiction the school can, and is expected, to provide a carefully worked out and effectively publicized plan for the proper care of pupils and school personnel when accidents do occur. It must also provide the necessary equipment for carrying out the specified procedures.

Instructions for care of emergencies. Since these are addressed to principals, teachers, secretaries, and other school personnel as much and sometimes even more than they are to the nurse, "instructions" seems a more appropriate term than "standing orders." The latter are associated with medical and hospital practice and are inaccurate as a description of procedures in emergencies, very few of which are medical. Each school system should work

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(and who will not?) is given an opportunity to read the tentative draft and offer suggestions. After such of these as prove acceptable are incorporated, a second draft is prepared. Submission of this to a representative or a health committee of the student body, the parent-teacher association, and to a school health committee of the local medical group may result in unexpected improvements in better understanding of and greater interest in the problems involved.

Instructions usually include the following information:

Telephone numbers

Of the nearest ambulance service (This may never be used and if it is, more generally it is for a member of the school staff than for a child. But if required, speed may be essential.)

Of the nearest hospital

Of the school physician

Of the nearest physician

Of a service through which some physician can always be obtained, if family physician, school physician, or nearest physician cannot be obtained

Of a school official who is to be notified when special help is required

These numbers may be different for the various school buildings of a school system.

Who takes charge in major emergencies? Major emergencies seldom occur in school but when they do, time is the first consideration. If the school physician is immediately available he takes charge; if he is not and the nurse is present, she may take charge. The nurse has an important part to play in educating the school personnel to waste no time in waiting for either the school physician or nurse when a serious emergency arises. The instructions should specify who is to take charge, including alternates.

Whoever is in charge should summon enough help so that four things can be done simultaneously:

1. Apply first aid to the ill or injured individual
2. Procure the nearest physician (or an ambulance)
3. Notify the school administrator
4. Notify the relatives

out its own instructions, for although the principles used are applicable to all schools, the methods used will vary according to such factors as availability of telephone service, medical service, hospital facilities, and parents. If a school physician is usually on call, if a nurse is ordinarily in the building, methods will differ from those developed for a school with no such staff members available.

The principles upon which the instructions are based include:

First, consideration is given to the protection of life and, next, to the prevention of unnecessary suffering.

Prevention of fear on the part of the individual concerned and also on the part of young pupils who may be present is important.

The school is responsible for the emergency handling of a sudden illness or accident but is not responsible for subsequent treatment. It is not only that its *responsibility* is limited to first aid but its *right* to give treatment goes no farther than such treatment as will protect the life and comfort of the individual until authorized treatment is secured. No internal medication is given with the possible exception of spirits of ammonia to prevent fainting.⁽²⁾

There are many advantages in the practice followed by some schools of requesting from the parent annually a statement of the name of the physician the parent wishes called if he cannot be reached and the child needs emergency care. It is desirable to have in the file a similar statement from each school employee together with the name of a person to notify if the employee is in such a condition he cannot assume responsibility for himself.

Preparation of instructions for care of school emergencies. The nurse participates in the preparation of the instructions. She has at hand for ready reference *Health In Schools*, *Suggested School Health Policies*,⁽³⁾ the Red Cross first-aid manual (American Red Cross: *First Aid Textbook*, to be secured from appropriate area office), and any pertinent state or local regulations. A tentative draft may be drawn up by a small group consisting perhaps of physician, nurse, principal, classroom elementary teacher, high school teacher, and physical education director. Every member of the school staff who will have some responsibility for care of school emergencies

gencies it may be advantageous to transport the injured person to the hospital on the school stretcher in a truck or private car instead of waiting for the ambulance.

Procedures in less serious emergencies. The issues in serious emergencies are clear cut without too many choices of action offered. The most troublesome problems arise in dealing with minor emergencies—whether to call a physician or take the patient to his office; whether to have him see a physician at all or take him home instead; whether to take him home or send word home for someone to come and get him. Experience and judgment are needed in addition to the latest first-aid instruction. When the nurse is available, her judgment is helpful. In minor emergencies it is often practical to have the patient wait for her scheduled arrival or send for her.

In the case of an injury, indications are usually fairly evident from the beginning as to whether it is major or minor. If there is a change in the classification it is generally from the more to the less serious.

Unidentified illness. With illness, the opposite is apt to happen. What appears at first to be quite minor, perhaps a mere headache or stomach-ache, may prove a little later to have been the onset of something serious, such as scarlet fever, appendicitis, pneumonia, or rheumatic fever. Whenever a child complains of feeling sick or is observed not to be in his usual state of health, an inspection and questioning, each as complete as possible, prove in the long run to be time- and trouble-savers. His general appearance is noted; throat and tongue are inspected. Any unusual odor is noted. Temperature, pulse, and respiration are taken. Almost invariably a reassuring comment can be made regarding the pulse and respiration rates. A careful inspection is made of all exposed body surfaces, especially of eyes and eyelids and behind the ears. Chest, face, and arms are observed for possible rash.

Conversation is directly along lines that may reveal any irregularity of eating, sleeping, or toilet habits that might be related to the way the child is feeling. Have any medications been taken? Has there been an emotional upset? Is anything unusually exciting happening at home or in school? Has there been any excessive

Procedure in major emergencies. It is especially important, if the case is serious, to limit first aid to what is actually needed to restore breathing, stop bleeding, and prevent shock and infection. Safety is put ahead of comfort, and moving the person is avoided. Hemorrhage is controlled by direct manual or bandage pressure, if possible, rather than by tourniquet. Severe burns are covered with sterile pads saturated with nongreasy fluid specified in the instructions. Compound fractures are not cleansed but are covered with a dry sterile dressing. Eye injuries are handled with extreme caution. Chemical burns of the eye are irrigated copiously at once with water. Skin burns about the eye are not treated with ointment but are covered with a sterile dressing and left for the physician. If removal of foreign bodies cannot be accomplished easily by washing or by a moist sterile cotton applicator, nothing more is attempted. More serious mistakes are made in the first-aid treatment of severe eye injuries than in any other common serious injury.

The patient with head injuries is kept very quiet, lying down with head elevated. Cold compresses may be used but no medications given. Pulse and respiration are recorded every 10 minutes. With chest and abdominal injuries the patient is kept very quiet, is given no medication and nothing by mouth. Pulse, temperature, and respiration are frequently recorded.

The criterion of good care is *not* to do everything for him and to do as little as possible to him.

If the physician or ambulance arrives before contact has been established with relatives, the physician and the person in authority at the school decide what shall be done next. They give primary consideration to the safety and welfare of the patient and only secondary consideration to unknown or imagined wishes of the relatives and to the various legal aspects. The nurse's knowledge of family circumstances and attitudes may make her advice helpful to the doctor and school administrator in arriving at the best decision. The nurse or other responsible member of the staff, designated by the person in charge, accompanies the pupil and stays with him until the parent or his representative arrives. In some major emer-

be taken of the medical help now available for such cases as it is especially important to avoid the formation of a mental attitude of invalidism in connection with the menstrual period.

Periodic absenteeism, prolonged absenteeism, excuses from physical education and other school activities present many problems as a result of dysmenorrhea. The nurse's teaching responsibility is to bring both girls and parents to regard menstruation as a normal function and to expect continuation of regular activities unless some abnormal situation is present. In these instances follow-up is comparable to that given for any other abnormal condition.

The nurse tells parent and pupil that usually the difficulty can be cleared up if the girl follows the physician's directions as to changes in daily living, exercise, and diet. There are many organic causes for dysmenorrhea, however, such as infantile uterus, ovarian tumors, uterine fibroids, narrowing of the cervix, or endometritis, which may require medical or surgical treatment. In some cases medication is needed. In only a few instances will surgery, which is so greatly feared by parents, be indicated. In the occasional case where it is needed, delay in securing it may be extremely serious. Treatment of any type should be instituted early in the girl's life; she should not wait until the time when she will be going to college or entering employment.

Even with normal menstrual function some girls have periodic headaches, mild abdominal discomfort, fatigue, tender breasts, and emotional upsets. The nurse in her teaching can help minimize these symptoms of mild dysmenorrhea. Mild exercises should be encouraged during menstruation. Most of the activities of the regular physical education program are rarely contraindicated during menstruation. Swimming is apt to stop the flow in some girls and is contraindicated for those individuals. For others it is not injurious. Jumping and horseback riding are harmful for some but, as with other more strenuous exercises, the danger varies with the individual. Since poor posture may cause menstrual pain, the nurse supports the posture program and assists girls in individual cases.

Constipation should be prevented by a proper regimen of diet and exercise at all times but it should be watched especially at time

physical activity such as running to school or for the school bus immediately after eating breakfast or lunch? Has a meal been omitted? Has some extra or unusual food been eaten? Has an unusual amount of a certain food been eaten? Is there an excess of homework, school, or family duties?

The information the nurse obtains will be more trustworthy if she has the pupil (or school employee) who comes complaining of a pain of undetermined cause sit down or lie down and discuss the situation with her in a leisurely and comfortable manner. The patient should be allowed to do most of the talking. Leading and direct questions are avoided as much as possible.

If the nurse does not know what else to do, she may safely recommend rest under her supervision, so that she may make direct observations. This is especially appropriate when malingering is suspected. Even though only subjective symptoms are reported the nurse has no right to say they do not exist. In fact situations most embarrassing for even experienced school people have occurred in connection with children who were chronic complainers but who did develop bona fide ailments which were ignored. Actually such persons are more liable than others to become ill so it is dangerous to assume they are always exaggerating.

Just as a school feels a moral responsibility to use its influence to get medical attention for a child who is ill at home, it should also feel responsible for a child who is able to attend class but who has some subacute condition which makes him periodically uncomfortable. If repeated requests to the parents to secure medical advice fail to get results the child can be excluded from school as not being in condition to profit by instruction. The parent is requested to obtain a medical statement. If the statement is not presented in a reasonable time as determined by the school according to circumstances, the case becomes one of illegal absence and is handled as such. (See Chapter 10.)

Dysmenorrhea. Too frequent requests to be excused from physical education are treated in the same way. Girls who are incapacitated by dysmenorrhea should be regarded as urgent cases for the nurse to follow up to secure treatment. Advantage should

by the family physician. Whenever a pupil requests such medication or rest periods the occasion may be used by the nurse to urge the pupil to see her own physician. Requests for excuses from physical education and other activities, as well as readmissions, present to the nurse an excellent opportunity to give individual health counseling. She should take advantage of each personal contact to give individual guidance.

Intermenstrual pain. School nurses who have had experience on a women's surgical ward will recall cases of intermenstrual pain which were admitted for differential diagnosis. This pain usually occurs at the time of ovulation which is generally about midway between menstrual periods.

From a surgical standpoint intermenstrual pain is difficult to diagnose without an adequate history, since the symptoms are similar to those of appendicitis. Therefore a careful history on such a girl kept by the nurse including data on menstruation is especially valuable.

Girls who have reached the age of puberty and complain of abdominal pain the nurse refers to the family physician as she would in the case of other illness needing medical attention. She can help the pupil trace the history of the present attack and question her concerning previous symptoms. Since history is one of the most important factors in the diagnosis of intermenstrual pain it is advisable for the nurse to impress upon the pupil the importance of giving the physician a careful and complete story of her symptoms.

Children with vague complaints. A child who comes to the nurse because he wants attention deserves her serious consideration. It is no solution and in some instances may be dangerous to tell the teacher not to let him come. The nurse first determines why the pupil must resort to such methods to secure attention. If she can, she works out with the teacher and parent a more desirable method for the pupil to use in securing attention. As a temporary measure affording an opportunity to study the child without encouraging him to come to her with imaginary ailments, the nurse asks the teacher to send him to her periodically on real or made-up errands. Often the cause of his disturbance becomes obvious to her after

of menstruation. Constipation is often the cause of discomfort because of pressure of an enlarged uterus and increased congestion in the abdominal cavity.

Emotional upheavals are a frequent cause for dysmenorrhea. These are sometimes occasioned by marital unhappiness in the home from which the pupil comes, an overly solicitous mother, or the rejection of the "woman role" in life on the part of the pupil. In severe cases of dysmenorrhea where organic reasons are ruled out as the cause of pain and discomfort, the nurse's observation of the girl may be helpful in discovering clues to other possible causes. It may be advisable to refer the girl to the child guidance clinic in the area. Because the nurse has repeated opportunities to talk over the problems with pupils, she may be able to help some girls with mild menstrual difficulties make necessary emotional adjustments.

Nutrition and medical, surgical, and psychosomatic treatment all play an important role in treatment of dysmenorrhea. Many studies have been made, and the findings have indicated the importance of each method of therapy.

Personal cleanliness at this time is another matter which is of the utmost importance in the high school girls' success in life. The nurse can stress importance of bathing and use of harmless deodorants. She can do a great deal to combat the still existent idea that bathing is injurious during menstrual periods. In her home visits this can be part of her parent and family health education. The nurse must be well informed about personal hygiene products as she will often be questioned regarding the different types. She will not be influenced by clever advertising. When in doubt she can refer the pupil to the family physician or she can always write for authoritative information to the American Medical Association, 535 North Dearborn Street, Chicago, Ill.

School medication for dysmenorrhea (as all other medication) is restricted to that ordered by the pupil's family physician in each individual case. Authorities have ruled that "standing orders" from the school physician for aspirin or any proprietary preparations are not permissible. Rest periods at this time may also be prescribed

Earache

Send child home and advise that he see the family physician.

Menstrual Pain

Rest on cot with hot-water bottle or electric pad applied to abdomen. If pain is severe and recurrent refer to family physician for cause and treatment.

Stomach-ache

Take temperature. Inspect. Question. If child appears to be ill, send or take him home, and advise that he be seen by the family physician. If child appears to be seriously ill, have a physician see the child before he is moved. Otherwise, have him rest on cot until he is better or worse.

Nosebleed

Have child lean back in chair with head tipped back, breathing through the mouth. Loosen the collar and anything tight around the neck. Apply cold wet compresses over the nose. Pressing the nostril on the bleeding side firmly against the middle partition often stops the bleeding and provides opportunity for a clot to form. If bleeding does not stop readily, call parent and physician.

Hysteria

Take temperature. Inspect. Question individual or associates to discover cause. Rest on cot, isolate where it is quiet. Cold compress may be applied to forehead. Follow up later.

Vomiting

Take temperature. Inspect for other symptoms. Make comfortable. Rest and quiet. If persistent, contact the parents and advise that the child see the family physician. Later inquire into recent habits.

Animal Bites

A special danger from animal bites is the possibility of rabies infection or hydrophobia. Animal bites of the head or face are especially dangerous. Secure a physician at once. Wash the wound thoroughly to remove the saliva. Use a gauze compress and a thick solution of soap and water to scrub the wound, then rinse it with clean running water and apply a sterile dressing as in other wounds of the skin. Always consult a physician at once so that Pasteur treatment will be given when such treatment is necessary. Never kill a biting animal. Isolate the animal and notify the health authorities.

some study and observation, but sometimes the help of the child guidance clinic is needed.

Another group of children puzzles the nurse with complaints of vague, indefinite discomforts with no objective symptoms but with repeated periods of "not feeling good." These are studied by the nurse for indications of an emotional basis of the trouble or for data indicating an underlying physical cause. Special records are kept as they are invaluable in effective follow-up. Rheumatic fever is always kept in mind as also the possibility of certain dietary lacks.

INSTRUCTIONS FOR CARE OF EMERGENCIES INCLUDE AS A MINIMUM:

Scratches, Minor Cuts, and Abrasions

Cleanse with boric acid solution; dry and apply sterile dressing (school physician may designate what antiseptic to use).

Bruises

Apply cold water or ice to bruised part for 10 minutes.

Burns

School physician designates the specific treatment to be used for severe burns and for minor burns.

Blisters

Apply sterile dressing.

Fainting

Place child flat on back with head low and loosen tight clothing. Apply aromatic spirits of ammonia to nose for inhalation. Do not try to have an unconscious person drink something. If fainting is prolonged call a physician. Fainting can often be prevented by lowering the head between the knees. When consciousness returns, temperature is taken, child is inspected, and cause of fainting is sought.

Headaches

If child appears to be ill, have him taken home. Otherwise have him rest on a cot. Cold compresses may be applied to the forehead. Take temperature. Inspect. Inquire regarding recent health habits, eyestrain, and the like.

- Bandages—1½ in., 2 in., 3 in.; at least 3 triangular bandages
- Adhesive (roll of assorted widths)
- Prepared dressings of gauze and adhesive (large and small sizes)
- Some form of liquid or jelly soap (expensive tincture of green soap is not necessary)
- Boric acid powder
- 3½% tincture of iodine or another antiseptic specified by the school physician
- Petrolatum (plain)
- Aromatic spirits of ammonia (with glass or rubber stopper)
- Medicated alcohol and boric acid solution
- Two types of medication for burns as specified for slight and severe
- Thermometers
- Medicine glasses and medicine droppers
- Bandage scissors and dressing forceps
- Splints and slings
- Kidney basins, large hand basins, a covered basin for boiling instruments
- Containers (jars) for solutions, cotton, opened bandages, etc. (containers adapted from materials on hand in homes are recommended rather than hospital equipment, for teaching value)
- Paper towels, paper cups, paper handkerchiefs

Kits. An emergency kit should be ready for the use of a physician, nurse, or other responsible person in case of accident or emergency where it is impossible to bring the injured or ill person to the health room. This may be in a strong cloth bag or box plainly marked "Emergency Kit" and should contain:

- Triangular bandages
- Gauze bandages, 1½ and 2 in.
- Gauze dressings
- Absorbent cotton
- Adhesive
- Applicators and tongue depressors
- Small containers of
 - selected antiseptic
 - selected treatment for burns
- Scissors
- Tube of petrolatum

Insect Stings

Remove the "sting" if it is still present. A baking soda paste, household ammonia, or a cold wet compress helps to relieve pain.

Snake Bite

Supply data according to poisonous snakes of locality.

Convulsions

Do not try to hold the child. Place him on the floor or ground so that he cannot fall, and loosen tight clothing. Put a wedge of wood such as a tongue depressor well wrapped with adhesive tape between his teeth to prevent his biting his tongue. Allow him to rest quietly on a cot after the convulsion. Report to parents and see that he is under continuous medical care.

Frostbite

Cover the frozen part with a woolen scarf or woolen stocking and thaw it out gradually in cool air or cold water. Do not expose to a hot stove, radiator, or fire until the circulation is restored by gradually raising the temperature through cool air or cold water. Put the child in a warm room and give him a warm drink. After first aid, unless frostbite is mild, the child should be taken home.

Hemorrhage

Apply pressure over the injury and elevate the part. Call parents and a physician if bleeding does not readily cease.

Cold, Sore Throat, Coughing, Sneezing, and Appearance of Fever

Isolate child from all others. Take temperature. Inspect. Send or take home as soon as possible.

Fractures and Sprains

Place in a comfortable position without moving a possible fracture more than is absolutely necessary. Keep warm. Contact the parents for authorization and send for the family physician.

SUPPLIES KEPT IN THE HEALTH ROOM

These may include:

Tongue depressors, applicators, and toothpicks
Absorbent cotton

that reference to them is easy as the work is being done. Stationary frames may be constructed so the old copies can be removed when they should be replaced by revised instructions. Manual arts students often make these. They are installed wherever there are first-aid supplies.

Supervision of first-aid supplies. Though the time of many nurses working in schools is too limited for them to take on the daily or weekly checking and refilling of first-aid supplies, any such nurse does need to assure herself that this is being done adequately and that no supplies not covered by instructions are placed in the cabinet. For this purpose she makes inspections at certain definite but unadvertised times.

She supervises arrangement of supplies so that they are convenient for use and so that it is actually more convenient in using them to do the correct rather than the incorrect thing; so that they are always accessible when needed; and finally so that they are not accessible to small children who might be injured by them. Supplies are not left on open surfaces because of dust, accessibility to small children, and the undesirable psychological implications. A wall cabinet, locked and with the key hung in plain sight but out of reach of small children, is one solution.

Provision is made for having articles which should be sterile, such as needles, dressings, and forceps, actually so when they are used; for keeping clean articles such as thermometers and tongue depressors.

First-aid situations in school are used to teach pupils and their parents procedures to use at home. The school cabinet is set up as a model for home use. Instead of large containers, use of small ones is a feature for economy and safety.

Notification of parents. Notification is expedited if health records have been properly filled out, are readily accessible, and have been kept up to date with present address, telephone number (or other information as to how the parent may be reached), and name of the family physician.

When notifying a parent of an accident or sudden illness, the nurse must be as considerate as possible and avoid causing any

The school nurse's bag. The nurse carries in her bag a few simple first-aid supplies of the sort every home should keep on hand, unless she has supplies from a motorist's first-aid kit available in her car. With these she is able to seize any opportunity that may come up in the course of her visit to include some teaching and demonstration of simple first aid.

There is no specified bag which the nurse should carry, but when making home calls some kind of a bag or brief case is essential. She carries with her some records, certain forms and writing materials, and several thermometers—one for mouth and one for rectum—and material for disinfecting them. She carries her own soap and paper towels for washing her hands before and after handling a child, although often it is not necessary for her to use her own materials for this.

A small flashlight is useful in making her own inspection and in teaching the parent the type of inspection which should be made of a child who shows signs of illness or who has been exposed to a communicable disease.

Since a fundamental purpose of the nurse's home call is to teach, the nurse is wise to use a variety of methods of demonstration and printed material, as well as word of mouth. Therefore, copies of popular bulletins obtained from health departments or other health agencies, appropriate to health problems discussed, are valuable for this purpose. If they are referred to during the discussion and if pertinent statements are marked, they can be left in the home with increased effectiveness.

A blank form for recording the pupil's health, on which the nurse may record the health history of a child who soon is to enter school, saves copying information later and adds dignity and efficiency to history-taking.

Since the nurse may have opportunities for teaching nursing procedures while in the home, a bedside apron is included.

The bag is selected by the nurse for its suitability to her own needs, its durability, attractiveness, and professional appearance.

Posting of instructions for proper use of supplies. These should be placed at eye height on the wall near the cabinet so

that reference to them is easy as the work is being done. Stationary frames may be constructed so the old copies can be removed when they should be replaced by revised instructions. Manual arts students often make these. They are installed wherever there are first-aid supplies.

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There is no specified bag which the nurse should carry, but when making home calls some kind of a bag or brief case is essential. She carries with her some records, certain forms and writing materials, and several thermometers—one for mouth and one for rectum—and material for disinfecting them. She carries her own soap and paper towels for washing her hands before and after handling a child, although often it is not necessary for her to use her own materials for this.

A small flashlight is useful in making her own inspection and in teaching the parent the type of inspection which should be made of a child who shows signs of illness or who has been exposed to a communicable disease.

Since a fundamental purpose of the nurse's home call is to teach, the nurse is wise to use a variety of methods of demonstration and printed material, as well as word of mouth. Therefore, copies of popular bulletins obtained from health departments or other health agencies, appropriate to health problems discussed, are valuable for this purpose. If they are referred to during the discussion and if pertinent statements are marked, they can be left in the home with increased effectiveness.

A blank form for recording the pupil's health, on which the nurse may record the health history of a child who soon is to enter school, saves copying information later and adds dignity and efficiency to history-taking.

Since the nurse may have opportunities for teaching nursing procedures while in the home, a bedside apron is included.

The bag is selected by the nurse for its suitability to her own needs, its durability, attractiveness, and professional appearance.

Posting of instructions for proper use of supplies. These should be placed at eye height on the wall near the cabinet so

No injured or ill child is allowed to walk home or to be unaccompanied by an adult if he has an obvious injury or condition such that it is reasonable to believe there can be a serious outcome or aftereffect. Included are head, chest, or eye injuries or suspected fractures, suspected communicable disease, or an elevated temperature. Protection of the school as well as the child is involved since the child legally remains under the school's supervision until he is put in the hands of his parents or their delegated representative.

Since traffic accidents may occur when a child is being transported there should be adequate personal liability insurance to cover the nurse's car or any car that is used for the purpose.

The school's "Instructions for Care of Emergencies" specify by whom arrangements for getting the child home shall be made.

Recording accidents. After an accident of any sort, to ensure accuracy a record should be made immediately. A carbon copy is kept in the nurse's file and the original sent to the office of the principal or superintendent as specified; or if there is a full-time medical director, to his office. It is desirable to have a form on which to make these reports in order that all necessary data will be included. Any accident, even one which appears minor at the time, may later become a basis for legal action. Accuracy is then essential as to date, time of day, witnesses, apparent extent of the injury, first aid applied, instructions given, and arrangements made for transportation of the child to his home. Contributing circumstances are carefully described, such as what the child was doing when it happened, what others were doing, and the exact site of the accident (its location on playground, building, in bus, or other place).

The nurse obtains specific instructions from her administrator regarding necessary insurance reports.

If a community study of all child accidents is going on, the form to be used in school can easily be set up to include whatever additional information is desired for the study, and an extra carbon made for the purpose. Greater specificity in describing the location and the activities which were involved may be the chief addition re-

unnecessary worry or shock. If the accident is serious it must not be minimized, as to do this might cause undesirable modification of parental action. In minor accidents, however, parents are sometimes thoughtlessly and unnecessarily frightened by the manner in which information is given to them. The statement that the child is not badly hurt but should lie down for a while and will be more comfortable at home is usually sufficient to bring the parent to the school to take him home, and does not cause undue alarm. Experience has shown that parents are less apprehensive if the child talks to them on the telephone. Of course someone supervises the call and is ready to take up the conversation to supplement information and to make definite plans for care.

The message given the parent includes a description of the exact place where the child will be found, the floor, the name or number of the room, and its relation to the entrance the parent will use. To many parents the school is an unknown place. If they do not know where to find their injured child and have trouble locating him, they may feel the school is unsympathetic and indifferent.

It is good practice for the nurse always to include in her statement to the parent concerning an accident or illness, no matter how trivial it may appear at the moment, "If he doesn't feel perfectly all right after a few hours (or by tonight, or by tomorrow morning, as the occasion may warrant), be sure to call your family physician." Only immediate first-aid treatment is the responsibility of the school. Further treatment is the parent's responsibility. If money is lacking for treatment, it is the welfare department, not the school which is responsible for further care. It may be desirable for the nurse to help the parent to secure this help.

Importance of getting ill and injured pupils home. If the child's condition is such that he may be removed to his home (or to the place designated by the parent as an emergency address) and if the parent cannot be reached or cannot come to the school for him the nurse is often the logical person to accompany the child. This is because it gives her an opportunity to instruct the parents or their designated representative regarding steps that should be taken.

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quired in order to allow someone not familiar with the school to analyze and classify significant factors. Also it may be necessary to include more about any characteristics of the individual which might have contributed to the accident, such as physical impairments or psychological or emotional traits.

Teaching. It is good mental hygiene to give instruction while giving care. Not only is the patient intensely interested, with the result he is in a good learning situation, but his mind is distracted from possible hysteria or self-pity. Also the more he takes part in the application of first aid the better. Showing him how to put away first-aid material properly is a part of the instruction.

At the earliest occasion possible following an accident, a discussion of its causes and how it might have been prevented is desirable. Sometimes this discussion is with the faculty alone; at other times the student body is included. The points of view of the pupil involved, his parents, and of his family physician are significant in some cases.

Effective instruction of school personnel can take place through discussion of procedures that were followed in a current emergency, contrasted with those both better and worse that might have been followed in other actual cases (or in anticipated cases). This is one method of developing judgment in handling emergencies. In such arranged discussions a school administrator and school physician should be present. The nurse will find her own judgment improving through the various points of view that will be expressed.

Before preparing material on emergencies to be printed or mimeographed and sent to all parents, a sampling of their opinions might be obtained by discussing with selected parents the problems involved. In this way their points of view may also receive proper consideration in setting up the policies to be followed.

The latest edition of the *First Aid Textbook* prepared by the American Red Cross should be in each school library and health room. The nurse works with the administrator to arrange for all members of the staff to have the Red Cross first-aid course and periodic refresher courses. Particularly good teaching films and other visual aids can be obtained. Since any member of the school staff may

render first aid, the health service staff should not be relied upon to handle all emergencies.

"Accident-proneness." A casual diagnosis of accident-proneness should not be tacked onto a child because he has been involved in more accidents than other children. It is especially important for lay diagnosticians to stay away from the popular conception that attributes the accidents of such children to subconscious intention.⁽⁴⁾

It must be kept in mind that some children because of their mode of living are much more subject than others to conditions which lead to accidents but which are outside of their control—fatigue, emotional stress, poor muscle coordination, impaired and uncorrected vision or hearing, onset of communicable disease, drunken drivers, icy pavements, poor housing, and other factors. Some have less and a poorer type of home supervision than others. Some have more initiative and in trying more new things normally anticipate more accidents.

As much and perhaps more professional skill is required for a reliable diagnosis of true accident-proneness than of other physical, mental, and emotional disabilities. The nurse can play an important part in securing such diagnoses. The school health record of the child is obviously of vital importance. Dr. John E. Gordan says: ⁽⁵⁾ "Much can be accomplished by incorporating the investigating of accidents into the ordinary activities of health departments where public health nurses and others include a consideration of accidents along with other activities which take them into the homes of people."

School participation in community safety programs. In her school work the public health nurse not only has the opportunity to contribute to scientific study of the occurrence and causes of accidents to school age children as they happen in school and on the playground, but also as they happen to him in his life outside the school as well. Because the school has contact with more families than any other community agency, it has also the best opportunity, one so far not developed, to participate in community studies of occurrence, causes, and prevention of all home accidents. Because of the obvious problems of obtaining accurate data on accidents

in the home, study and prevention in this field have lagged far behind progress made in the prevention of industrial and traffic accidents. Such studies as have been made on home accidents have often been limited to those resulting in fatality or at best to those admitted to hospitals. If, as estimated in home accidents, some 150 disabling accidents occur for every death, it is clearly impossible to develop a comprehensive preventive program without more adequate knowledge concerning all home accidents.

Accidents are the first cause of death for children between the ages 5 and 15 as well as for youth between 15 and 24 years of age. The school therefore has every reason to direct all its resources toward accident prevention. Likewise the first cause of death for children aged 1 through 4 is accidents, and just as the school is active in the community's program to get these younger children immunized at the proper time even though they are not yet the school's responsibility, so it can fight this equally serious danger that threatens to cripple and handicap the children it must educate later.

Dr. D. B. Armstrong of the Metropolitan Life Insurance Company states that although the accident death rate among insured children in the age group 1 through 14 showed a 29 per cent reduction during a recent 15-year period, this decline was not consistent and compares unfavorably with the reduction in child deaths due to disease. As a result, accidents today represent the first cause of death among children and a major child health problem.⁽⁸⁾

Taking part in a community program for child safety is an appropriate activity for a school health council. Carefully chosen members of the council, properly directed, have been found competent to assist by such activities as:

Interviewing city officials and officers of community agencies to obtain information for an inventory of what is now being done and the resources of the department or agency for participation in the program.

Acting as a recorder for a professional person, such as an engineer or insurance inspector, in making a survey of physical conditions, which may affect child safety in such public places as the streets with their traffic problems, playground and public recreation areas, school buildings and playgrounds, and especially in unsupervised areas where children habitually play, such as "sand lots," empty buildings, and certain streets.

regarded by the family as of minor importance. These are (1) dog bites which should be considered for Pasteur treatment, and (2) contaminated or puncture wounds for which tetanus prophylaxis is indicated.

The nurse regards these as urgent emergencies and asks the principal to exclude the children until they have had medical attention. If unable to contact the parent by telephone, she accompanies the child to his home so she may state the case most effectively and if necessary, help the parent make arrangements to secure immediate medical attention.

Usually the sanitary code of a state requires every person—whether a veterinarian, police officer, or other person having knowledge of the existence of an animal apparently afflicted with rabies—to report immediately to the local health officer the existence of such an animal, place where seen, owner's name if known, and symptoms suggesting rabies. Instances in which such an animal bites a human being must be reported promptly. This is necessary in order that the health officer may do his part in securing needed treatment for the person bitten, and also so that he will know at the earliest moment of the suspicion of rabies in the community and take immediate steps for control.

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The Nurse's Part in School Health Recording

Special responsibilities of the nurse. Whether the nurse or the teacher should be responsible for keeping the pupil's health records is a question frequently raised and infrequently settled. Perhaps this is because it is not a question of either one or the other. To keep proper health records of pupils involves much more than assigning responsibility for them to a certain staff member. Many must participate.

A nurse's specific activities in relation to records vary greatly from nurse to nurse, and even in one nurse's assignments from school to school. But regardless of what her particular activities may be, every nurse has definite responsibilities in regard to record keeping—or, we may better say, record production. These responsibilities have to do with (1) setting up a proper system of record forms, (2) placing of definite responsibility upon a specific staff member for gathering and recording items of essential information, (3) developing methods which facilitate the most prompt, reliable, and economical transfer of pertinent information between the school staff and the parents, family physician, dentist, clinics, and other cooperating agencies, and (4) recording her own observations about the child promptly, precisely, with clarity and economy of time and effort.

Unless there is a full-time medical director, the nurse is usually the person most aware of the value of a health record which gives a fairly complete picture of the whole child. In establishing a record system, the nurse should work with the school administrator, physician, and teachers to secure mutual understanding and cooperation and to ensure complete and authentic records.

Purposes of school health records. The core of the school health record system is the individual cumulative health record for each pupil. For the "normal" child as well as for the "problem" child, its purpose is to supply the information needed for a continuous health supervision which is positive, constructive, and protective, as well as corrective. The health record must picture the growth and development of the child as well as his defects, and only incidentally does it indicate the nurse's activities. When properly designed, kept up to date, and studied, such a record also identifies problems which require special consideration and may indicate steps in treatment. It furnishes opportunities to evaluate the services which have been rendered to the child.

Without effective records it is impossible for school authorities—or health authorities, if they are responsible for the school health service—to know that each child is receiving the health services to which he is entitled. The record shows what is planned for him and what he has received.

In the many schools of the country where health service is still in a pioneer stage, a periodic review of all the records gives a general picture of unmet needs of the children as a group. It furnishes an opportunity for the school and community to evaluate the situation as a whole and plan to care first for the most acute. The same sort of general survey is required also in established health systems to permit the most thoughtful planning for the development of additional resources to meet future demands.

Increasing the teacher's understanding of the child. With present-day emphasis on the value of a teacher's understanding of the child as a person if she is to be most effective in helping him grow into the kind of citizen desired, the importance of a proper health record increases. When she includes all aspects of healthy

growth—mental, emotional, and social, as well as physical—the teacher's understanding of the child is broadened and deepened. If information obtained from the family by the physician and nurse is shared with the teacher, she can understand many things about the child which might otherwise be unknown to her. Physician and nurse not only have different opportunities for learning about the child, but their professional backgrounds enable them to see different aspects from those his teacher sees. Each of these three—teacher, physician, and nurse—has something special to add to what the other two may observe. Some of this knowledge is best shared through personal conference, but that which can be properly incorporated in a record will contribute to future as well as to current interpretation of the child.

Helping his family. The child's family, family physician, and dentist are better able to care for him when the school staff share with them the results of screening tests for vision and hearing, periodic weighing and measuring, findings of medical and dental inspections and examinations, and the continuous observations of the child as he conducts himself in his school life by school physician, school nurse, and teachers.

Continuity of service. Another and vital purpose of the record is to ensure continuity of service to the individual pupil. In his school life, he encounters not only the unplanned changes in personnel due to illnesses, promotions, and resignations, but also the expected changes which occur as the child progresses through kindergarten, elementary school, junior and senior high school. A public health nurse carrying a general service can have no expectation of giving a child all of his school nursing service. The number of families required to furnish enough children to warrant even a minimum-sized high school is too large for one nurse. It is a rare situation when even the specialized school nurse's assignment is such that she follows the child from school to school. The record then must be planned with the thought in mind that it is to be used by many different nurses, as well as many physicians and teachers.

Planning the program. Another purpose of these records is to furnish to school and community data on the nature and causes of

problems interfering with the health, growth, and development of school age children. If the records are unusually good they may give information about the comparative effectiveness of various methods used in dealing with these problems. As a basis for intelligent planning for program and personnel, such data are essential.

Forms. The most simply organized school health service will find essential the following types of forms:

One on which a cumulative permanent individual health record may be made for each pupil

One with space for recording only one examination, on which the family physician who examines the child in his own office for the school health program sends his findings and recommendations to the school

One which the school uses to report to the parents the results and recommendations from the child's examination in school

A variety, perhaps of the memo types to use in transferring specific items of information back and forth between teacher, nurse, physician, principal, etc.

Components of the pupil's cumulative, permanent health record

IDENTIFICATION. A first requirement is complete identification of the pupil. His name, spelled as it appears on his birth certificate, is used. For convenience, the name by which he prefers to be called may be underlined. Sex and place and date of birth as established by the birth certificate are recorded. Typewriter or ink is used for these items, and for names and birthplaces of parents. His present address, address of his parents or guardian, and name of the family's physician may be entered in pencil.

The above information may be entered by clerk, teacher, nurse, or volunteer, as decided by the administrator, since reliability but no professional judgment is required.

FAMILY HISTORY. In most schools the initial family history is confined to such items as: age and general health of parents if living; date and cause of death if deceased; occurrence of tuberculosis in any family or household member; identification of brothers

an administrative and clerical function, and should not concern physician, nurse, or teacher.

Family folder. Family folders are set up for children when more work is done with their families than can be recorded conveniently on their health record cards. A notation, perhaps in red, is made on the front of the card of each child in the family indicating the existence of a family folder.⁽¹⁾

Filing. In schools with limited nursing service it is quite a general practice to have each teacher keep the records of her own pupils. Sometimes they are kept in a central file in the principal's office.

With adequate medical and nursing service the convenience of having them filed in the health service office becomes evident. Work on them is done either directly by a member of the health service staff or under close supervision of such a staff member. Teachers find it just as convenient to use them in the health office as in the principal's office. In fact they often find it more satisfactory to have information interpreted to them by the physician or nurse rather than to try to take it directly from the records.

The nurse finds that filing health records in classroom groups, in manila folders labeled with the grade and the teacher's name, is convenient because so many of her activities with them are carried out on a classroom basis. Also this arrangement saves time when assembling cards for her teacher conferences, for physician's examinations and inspections, for her own testing program, her recording, and for her pupil conferences. Occasionally she may need to use the alphabetical file in the central office to learn the room location of an individual child.

Some schools have tried to use various types of "visible" files for health records but with little success. One difficulty is that entries must sometimes be made on both sides of the form concurrently. Another is the amount of changing required when pupils are transferred during the term, if the cards are to be continued in order. In some instances this has resulted in a tendency to have the printed form too crowded and space for entries too small in

order to have the card conform to index size. If conservation of vision for those who work with the cards counts, a card, 8½ in. by 11 in., with space for only a 7-year record is as small as is practical. This means a minimum of two cards is planned for each child's school life.

The most serious problem involved in the use of visible files is lack of provision for a second card and for the various other supplementary records often required.

Protection and proper use of records. The pupil's cumulative health record is held as a confidential record. It is kept in a fire-proof place. In instances where only the safe is fireproof this may require assignment of high school pupils to carry the locked file between the health room and safe, night and morning.

Except when they are under supervision of an authorized person (principal, school physician, nurse, dentist, dental hygiene teacher, other teacher, attendance supervisor, or clerk), records are kept under lock and key.⁽²⁾ They are directly accessible only to the personnel approved for the purpose. In some instances it is found more satisfactory to have information abstracted and interpreted for others by the physician, nurse, or clerk.

Whenever records are removed from the room in which the files are located for the nurse or someone else to work on, a note is put in the file in their place with the name of the worker and the date. By definitely charging them to a certain person, the importance of returning them is emphasized and makes it possible to trace them when they are missing.

A transcript or the original record, as preferred by the school, is sent to the school to which a pupil is transferred.

Information from records is given to individuals or agencies outside the school only when the request comes to the nurse with the school administrator's approval. He will approve requests signed by the parent for appropriate information to be given to health personnel of cooperating agencies, such as the Y.W.C.A., Y.M.C.A., 4-H Club, summer camps, and other unofficial health and welfare agencies. Direct requests are honored from the children's court judge, law enforcement agencies, and health departments.

which to be alert. The manner in which these two professional staff members record their own observations of the children and the methods they employ in stimulating proper use of this information by other members of the staff—and sometimes by parents and family physicians—are of true educational value to the rest of the staff.⁽³⁾

Physician and nurse also have a greater responsibility than other members of the staff for constantly reviewing the forms and blanks in use to ascertain if there is provision for entering all desired items with a minimum of time and effort.⁽⁴⁾ Equally important is the elimination of items no longer significant or already available from other school records. Parents have a right to resent repeated requests for information. The responsibilities listed above are carried jointly by the school physician and nurse. When the physician is in the schools part time, the nurse carries a greater responsibility than when he is a full-time staff member. This is apt to be true even when the nurse also is in school part time.

Recording physician's examination. In an early stage of the development of a health program in a school system, it is usual that some other person records the physician's findings as he examines the pupil. This is most often the case when his examination is of the two-minute inspectional type. Pupils pass in front of him so rapidly he has no time to record. He may attempt to justify his public declaration of "tonsils three," "nutrition one," "teeth seven," "hygiene," "heart two," with the argument that such phrases are meaningless to the children. Therefore, he insists, there is no offense against good mental hygiene practice for the pupil, and the other children are unaware of what is being recorded. Some of the children catch on quickly. To them the word "hygiene" will always be associated with "dirty" and will have a bad connotation; others will misunderstand. When a child hears something said about himself which he does not comprehend, he may worry about it more than if he knew what was meant.

In some instances the doctor waits to dictate the record until the child has left. This cannot be justified by a claim of time saved, and if the doctor is examining children in quick succession, there is opportunity for errors and omissions.

In more modern school health practice the physician gives the kind of examination found to be most valuable as a school experience for the child—one leisurely enough for both to be seated at intervals, with time for them to engage in a little unhurried conversation, and with the physician including some health instruction or comments designed to change an attitude of child or parent. In such a situation the physician finds he can do his own recording more satisfactorily and require little if any extra time. This assumes that such data as visual acuities, hearing scores, weights, and measures have already been entered, leaving for him only those entries requiring medical judgment.⁽⁵⁾

This fact must be faced: If on the cards there are to be recorded only comments which the pupil may hear or see, either practices are being used which are poor from a mental hygiene point of view or much is being omitted which might be helpful to the school staff in understanding and planning for the child.

For the physician who examines the school child in his own office as part of the health program, a special blank form is provided. It contains items appearing on the cumulative record form but with space for entries only for the current year. The cumulative record never leaves the school. The form furnished the family physician may have two parts, one to be kept by the physician and one to be returned to the school. Or he may be furnished with two copies of the form for each child, so he may make a carbon for the school and keep the original for his own files. For the most satisfactory system, such a form—in fact the whole plan—is developed by a committee made up of representatives from the health service and of the physicians participating in the program. More success has been achieved in developing ways for the school to obtain information from physicians than in developing ways for the school to share information with the physician who is to do the examining in his office.

Procedures vary for handling the form recording the child's examination in a physician's office. Some schools clip together the forms for the various years. Others copy the findings each year on the cumulative form and file the original individual reports in

an inactive file for possible future reference. A specially trained clerk may do the copying, but before the record is filed it should be reviewed by the school physician or nurse, as professional judgment may be needed in interpreting the family physician's notations in terms consistent with those used by the school.

Use of a code. Only code symbols or words explained on the form itself should be used so that any future worker in a school using the record will have an exact definition immediately at hand. (See Chapter 10.)

Changing record forms. Instead of ordering forms revised frequently, if they have been well set up originally, it may be possible to insert new items by using a rubber stamp. This is a time-saver, but it is well to remember that omissions are less apt to occur if all cards are stamped at once, instead of relying on memory to insert the new item as each card is handled.

When new record forms are introduced the current records are entered on the new one and the old form is stapled to it. No attempt should be made to copy from the old to the new. Not to speak of time saved, it is axiomatic that an original record is more valuable than a copy. There was a stage in the development of school health services when it was considered desirable to limit the child's health record to the amount that could be entered on one card. Print became smaller and smaller, spaces for entries shrank, until a point was reached where the crowding defeated its own purpose.

Current procedure is to have at least two forms, planned to cover the entire period of school life, each allowing for a 7-year minimum record. The first covers roughly the first half of the child's school life, from kindergarten up to junior high school, or through the fifth or sixth grades, depending upon the type of school organization. The second covers junior and senior high school years. Space is allowed for two extra years for pupils whose schooling is interrupted. These two minimum forms are used for all pupils, supplemented by a number of optional forms to be used as indicated. The latter are usually special forms for pupils with serious prob-

lems, such as those of vision or hearing, heart, orthopedics, posture, orthodontia (assuming a general dental record for all pupils), tuberculosis case or contact, or perhaps those requiring special guidance or mental hygiene supervision.

A health folder for each child becomes an essential as health services become more adequate. Some schools print the cumulative record forms on the inside of the folder itself. A number of schools have experimented with visible index cards, but they have proven unsatisfactory because of the day-by-day entries that are required.⁽⁶⁾

Recording equipment. Simple but essential equipment and supplies include desk or writing table of adequate size and height suitable for the nurse's build; chair fitted to her; sufficient filing space within easy reach and with manila folders and guides to keep materials easily accessible; good lighting; medical and standard dictionaries; official publications of the state departments of education and health; large desk calendar and/or appointment book; pen with a fine point; typewriter; eraser and ink eradicator; dark and red ink; date stamp; stapler, paper clips, color indicators, and other useful small items. Files are also needed to keep supplies of forms, reports, printed and mimeographed materials in alphabetical order for easy accessibility.

Recording day-by-day health supervision. There is no one system of recording day-by-day health supervision which can be prescribed for use in all schools. When there is a generous amount of clerical service available, methods can be worked out that reduce to a minimum the time required of classroom teacher and nurse.

When clerical service is limited, the following methods have been found economical and effective. Whenever possible entries are made directly on the record. For occasions when this is undesirable, a temporary blank card is used. The child's name and home room may be all the identification needed. These are not made out for all pupils, but as the nurse wishes to discuss something about a child with the teacher, she may begin one for him or if the teacher has something she wishes to call to the nurse's attention about a certain

child, she may make one out for that child. Then the card is used as long as that child is with that teacher. For the unusual child additional blank cards may be stapled to the original one.

For a pupil who has problems which must be called to the attention of his parents, two carbon copies of the notification to the parent are made. One is given to the teacher, and the nurse keeps the other. When the parent returns the notice the teacher notes on her carbon anything of interest. If the problem has been taken care of, neither nurse nor teacher needs to keep her carbon any longer. The nurse keeps the one from the parent until the proper notation is made on the cumulative health record.

When the nurse has a conference with the parent of a child whose problem has not been taken care of, she enters her notes directly on her carbon or, if that space is insufficient, staples extra paper to it. When she returns to the school, she shares with the teacher such information as is indicated. She enters on the pupil's cumulative record an appropriate summary. Should a more comprehensive account be desired than there is room for on the record, she indicates on the record that supplementary material regarding the parent conference is available in the family folder, or in a special folder of family conferences, as the case may be. The teacher also records her conferences with parents on her carbon.

During the two final months of each school year, or during the final month of each semester, if pupils change teachers semiannually, nurse and teacher schedule a conference. The nurse brings the permanent cumulative records, her carbons of the notices to parents of children whose problems are still uncared for, and the temporary cards with their day-by-day entries. The teacher has ready the pupils' attendance records and her carbons of the notifications to parents. Together they decide what is of permanent value and should be entered on the cumulative record. When this is a new procedure to the teacher, the nurse may make entries for the teacher as well as for herself, but after several such experiences the teacher finds she can make her own more satisfactorily. The recorded data which each brings to this conference prove to be only a fraction of

the information exchanged about the majority of the pupils discussed, as many things come to mind which have not been recorded.

Nurse and teacher have a similar conference early in the fall. As soon as school opens, a simple questionnaire is sent home with each pupil, asking for information about what has happened to the pupil during the vacation period, what immunizations or dental work he has had, what illness, accidents, or operations. Is the physician named previously still the family's choice of a physician to be called in an emergency should it be impossible to get in touch with the parent? In a family where both parents are frequently away from home, or where the home has no telephone and is located far from the school, a relative or friend should be designated in whose care the child may be placed in case of an emergency. The teacher brings this information to the conference, and the nurse brings the cumulative records of the teacher's new pupils. The nurse explains any special recommendations that have been made for any of the children. Any pertinent new data from the questionnaires are entered on the cumulative records. Although the teacher has had the pupil only a few days, she may have observed something which should be called to the physician's attention.

Planning for reporting of home visits. The use which the nurse herself may make of information gained in a home visit may seem to her sufficient justification for time expended in making a home call but it is actually only a fragment of the potential values. The promptness, accuracy, and perspicuity with which the nurse makes her reports of the visit have much to do with a full realization of these values.

A minimum record is entered in the nurse's day book and on the pupil's health record. For her own convenience later, the nurse records her answer to the question, "What do I need to have in mind the next time I contact that family or the pupil?"

By note, telephone, or conversation she notifies other nurses in the school system (under some circumstances, nurses of other school systems) concerning children involved who attend school in buildings not served by her.

To public health nurses and personnel of other cooperating agen-

cies, she refers cases or passes on indicated information concerning orthopedic cases, pregnant mothers, suspected tuberculosis, etc.

To social and welfare workers, she gives such information as they should have.

There are home calls to which the last three activities have no application. In every instance, however, the nurse asks herself, "What do I know about that home, the family, or the children that would help the teacher of the child (or siblings) to understand him better or to help him more effectively?" This she discusses with or writes to the teacher.

In every instance, also, she asks herself, "What do I know about that home, that family, or those children which next year (or at any future time) would help me or my successor, the guidance director, the attendance supervisor, the teacher, or the school physician in dealing with any of the children?" Such material, if very brief, and if it applies to one child alone, may be entered on the pupil's health record. Usually a family folder of some type, perhaps set up in conjunction with the record systems of the guidance and attendance departments, is needed. Time for, means of, and procedures for doing all these things after making a home call are worked out by the nurse, school administrator, and health director. Definite schedules are planned for nurse-teacher conferences, nurse-attendance worker, and nurse-guidance director conferences.

Whenever several people need the same information, arrangements may be made for the nurse to dictate the material so carbon copies can be made. It may be considered advantageous to have all such information pass through a central office and to have all communications to cooperating agencies channeled through one school official (as through school physician to health officer, from superintendent to welfare officer, etc.).

Data involved in planning and reporting a home visit.

PART I

Information needed before visit: Pupil's name; address; parent's name and occupation; brothers and sisters in school; problems (habits, defects—present effects and possible future effects); scho-

lastic status; attendance record; other significant items from history.

Activities suggested to precede visit: Conference with child to check on status of condition for which the visit is being made and review of correctness of name, address, siblings, etc.; verification of accessibility of parent at time of prospective visit—through child, an older child, phone call, or note to parent (if parent does not speak English arrange for an interpreter); review of health and attendance records of this child and of his siblings; conferences with school personnel who may have pertinent information not recorded; checking with social service exchange, other agencies where indicated; checking to see if other calls in the neighborhood are indicated at this time.

PART II

Interview with parent: Parent's attitude toward problem, adequacy of his awareness of it; his plan to meet problem; if none, development of plan to meet it; definite understanding of next step and who is to take it.

PART III

General information for better understanding of the child and family by school personnel: (Not all will be included on all calls.) Parent's attitude toward children (indulgent, too severe, partial); lack of supervision, indifference, maladjustments due to foreign background of parents, etc.; parent's attitudes toward health in general, toward illness, toward medical and nursing care, clinics, hospitals, social agencies, etc.; attitude toward education (lacking ambition, too ambitious, etc.) and toward school personnel.

Health problems of nonschool members of the family.

Economic status (sound, chronic poverty, temporary economic strain, seasonal income, etc.).

Social status (type of neighborhood, books and magazines, use of leisure, participation in community activities, racial background, education of parents, etc.).

Physical environment of home (adequate space for study, sleeping, and play; sanitation; comfort; attractiveness, etc.).

Family atmosphere (good management, harmonious relationships, broken home, outsiders in home, etc.).

Data about family eating and food habits; children's sleep habits; children's work and play habits.

Health instruction given beyond initial purpose of the visit.

PART IV

References of information or requests for help to school personnel or community agencies.

Improving the nurse's recording. Working out a satisfactory method for keeping records in a specific situation is a problem requiring detailed knowledge of that situation and familiarity with general principles of recording, classifying, and filing, if the plan is to result in complete, accurate, readily accessible information with a minimum expenditure of time.

Recording requires time and time must be budgeted for it. Often it is not the fact that the actual recording is time consuming which accounts for the active dislike for recording held by certain nurses. The really difficult process, and the one which may stand in way of adequate recording, is the thinking which must be done before the nurse knows what to record.

As a part of her nursing education a nurse has learned to make brief, accurate notes on her observations of a sick person in formal, almost stereotyped phrasing, as significant as possible to the physician and confusing to any lay person who might inadvertently read it. Now she must teach herself to record in such a way that lay people will understand and she must go beyond the cryptic brevities so valued in the hospital. There, someone other than herself usually decided what information was of value to record, what was of value to be saved for a later date, how it should be preserved, where and under what classification it should be filed. Here, she must decide many of these questions for herself. A wise nurse seeks guidance from specialists in this field just as she advises others to seek expert guidance in health matters. She is quick to refer to the administrator or the medical supervisor decisions which are not hers to make but which are in their province.

The very mass of information concerning a child which a school may have available may itself contribute to the difficulty in making a good record. When the nurse's own philosophy is vague about what she is supposed to be accomplishing or just what her responsibility is, she feels frustrated and unsure of herself when she tries to record. To decide what is significant, what is the concern of this particular record, and what should be discarded requires a judgment and perspective which the new nurse may need some time to develop.

When working to develop skill in recording the nurse might find it good practice at first to record practically everything. A school nurse usually has two types of records. The first she may refer to as "my own." This may be a notebook or daybook, perhaps in diary form in which she notes anything and everything—future appointments, conferences with parents, requests from teachers, first aid, telephone calls, supplies that are needed, tentative ideas about problems, plans, and any other item she does not want to forget.

The second type of record is made from this miscellaneous assortment and may be an entry on one of the official forms already mentioned or it may become a part of a routine or special report. As the nurse enters these on another record she crosses the item off her daybook. After a week or two she reviews the remaining items, discards some of them as trivial, rewrites some, and condenses or summarizes others.

Rereading these items, she may realize omissions in her original notations, perhaps actual omissions in her observations or in activities upon which entries were based. She sharpens her ability to serve, to interview, to observe by her evaluation of her own processes. She gradually learns to omit the type of notations which are later discarded. Through interpretations she adds later she increases her ability to consider an increasing number of factors when making an original record.

In the nurse's "own record," she uses her professional vocabulary and professional abbreviations with precision. This is true also for the pupil's individual health record card as the latter is primarily

a medical record and always subject to professional interpretation by the physician or nurse to lay people.

When recording on the pupil's cumulative health record, temporary conditions of no future significance are omitted, as they might later be interpreted to the pupil's detriment.

In records and reports designed for lay people she reviews all her statements carefully to translate all professional terms (and especially professional patter) into clear English.

The use of the third person, such as "the nurse," is often desirable instead of "I." When the first person is used, "we" is sometimes preferable to "I."

Vocabulary for use in recording behavior problems. A definition of terms and a key are included in Publication 317 of the Federal Security Agency, Social Security Administration, Children's Bureau. These are helpful to an inexperienced nurse in recording behavior problems.

Use of abbreviations, signs, and symbols. These have no place in reports. In recording they may contribute to speed and space-saving. As said before certain signs and symbols are included in the code printed on the pupil's individual health record for the physician's use in recording his findings. The nurse utilizes these for her own records. Personal abbreviations are avoided. The following list includes most of these commonly used, and all are found in a medical or general dictionary.

adm.	admitted	bldg.	building
adv.	advised	b.m.	bowel movement
agcy.	agency	bro.	brother
A.M.	morning	bp.	birthplace
amt.	amount	ē	with
ans.	answer	C.C.	crippled children
ant.	anterior	c.d.	communicable dis-
approx.	approximately		ease
appt.	appointment	ch.	child, children
apt.	apartment	clk.	clerk
arr.	arrange	cond.	condition
assn.	association	conf.	conference
b.i.d.	twice daily	C.P.	chickenpox

C.P.	cerebral palsy	neg.	negative
d.	died	no.	number
dau.	daughter	norm.	normal
D.D.S.	dentist	nsg.	nursing
dec.	deceased	nutr.	nutrition
demon.	demonstrated	obs.	observation
Diph.	diphtheria	O.I.	correct
disc.	discussed	oz.	ounce
disch.	discharged	P.	pulse
dism.	dismissed	palp.	palpable
Dr.	doctor	P.H.N.	public health nurse
econ.	economic	phys.	physical
el. sch.	elementary school	P.M.	afternoon
esp.	especially	pos.	positive
etc.	and so forth	post.	posterior
exam.	examination	pph.	pamphlet
excl.	exclusion, exclude	preg.	pregnant
expl.	explanation	prin.	principal
freq.	frequent	p.r.n.	whenever necessary
G.C.	gonorrhea	prob.	problem
hd.	head	presch.	preschool
hdqrs.	headquarters	psych.	psychiatric exami-
H.O.	health officer	exam.	nation
H ₂ O	water	pt.	patient
hosp.	hospital	q.	every
H.S.	high school	q.s.	quantity sufficient
ht.	height	R.	respiration
h.v.	home visit	rd.	road
id.	the same	re	regarding
immun.	immunization	rec.	recommend, recom-
in.	inch		mendation
incr.	increased	ref.	referred
inf.	infant	reg.	regular
insp.	inspection, inspected	rpt.	report
irreg.	irregular	R _x	prescription
J.P.	justice of the peace	̄	without
lbs.	pounds	san.	sanitarium
lit.	literature	sch.	school
memo.	memorandum	secy.	secretary
menst.	menstruation	seq.	sequela
M. Hyg.	mental hygiene	S.F.	scarlet fever
mod.	moderate	sgd.	signed
n.	nurse	sibs.	siblings

a medical record and always subject to professional interpretation by the physician or nurse to lay people.

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amt.	amount	ō	with
ans.	answer	C.C.	crippled children
ant.	anterior	c.d.	communicable disease
approx.	approximately	ch.	child, children
appt.	appointment	clk.	clerk
apt.	apartment	cond.	condition
arr.	arrange	conf.	conference
assn.	association	C.P.	chickenpox
b.i.d.	twice daily		

communication, even if it cannot be answered at the moment, is vital. Careful use of correct name and proper title of the person addressed, exact identification of the case under discussion, and a statement in simple language of the reason for writing the letter ensure an open mind on the part of the reader. If the nurse specifies some assistance she wants, adding "Or would you care to suggest some other procedure?" is a gracious touch. In some instances the nurse finds that preparing the letter for signature of her medical inspector or principal secures more effective attention than writing over her own name. When she does sign her own name, her official title is added. Use of official school stationery is usually indicated.

Effective recording and reporting improve service. By her study and analysis of what she has done, how she did it, and what her results were, the nurse improves her ability for service as well as for the recording. Comparison of her results with one pupil with her results with another when a different method was used, and comparison of her own methods, procedures, and accomplishments with those of other nurses is a means of self-education made possible through good recording. Practice in the accurate observation and the careful lucid writing required by recording increases the nurse's accuracy and carefulness in her work.

Reviewing a record of what she has done enables her to determine incomplete service or omissions.

An important activity in a nurse's self-supervision is made possible by study and analysis of her unsuccessful cases to determine possible causes of failure.

Good recording and reporting in the more effective administration of health service. Records are essential administrative tools. They reveal the necessity for changing policies or practices. They provide opportunity to analyze and clarify what the services are and what they should do. They may indicate need for additional staff or for reassignment of present staff. When questions are raised by taxpayer groups or prejudiced critics it is valuable to have evidence at hand justifying activities and expenditures. Records ensure a continuity of service despite change of personnel.

sis.	sister	Tb susp.	tuberculosis suspect
sn.	sanitary	tchr.	teacher
soc.	society	therm.	thermometer
sol.	solution	t.i.d.	three times daily
S.P.	smallpox	T.P.R.	temperature, pulse, and respiration
st.	street	tr.	treatment
sug.	suggest	transf.	transferred
suppl.	supplement	tt.	toilet training
supt.	superintendent	Typh.	typhoid
surg.	surgery	u	umbilical
Syph.	syphilis	vac.	vaccination
T.	temperature	V.D.	venereal disease
T & A	tonsillectomy and adenoidectomy	W.C.	whooping cough
Tb	tuberculosis	wk.	week
Tb case	tuberculosis case	wt.	weight
Tb con.	tuberculosis contact	yr.	year

Use of a folder for ideas for planning new work. Too seldom does a nurse doing school work have an opportunity to sit down for a day or a half day or even an hour to consider what changes she might make in her program or her method of work. But as she is busily engaged in something she cannot stop, or perhaps as she is reading on a train or listening to the radio, ideas come to her. Use of a special folder into which she may drop clippings, articles, or a brief note of her own may provide desired stimulation to her thinking later when she is considering her annual report or plans for the next year.

Record of correspondence. A lock file, letter size, is desirable for letters which the nurse receives and for carbon copies of letters she writes. It is possible to make carbon copies of handwritten letters, but for official correspondence the nurse should endeavor to secure stenographic assistance. When information about a pupil or his family is furnished to a cooperating agency a copy of it is kept. When the nurse fills out legal papers, information is recorded that she may be asked for later by another agency, and it is a time-saver to be able to refer to it.

Good letter writing makes an important contribution to good public relations. Promptness in acknowledging a request or a

5. Wilson, Charles C.: "School Health Services in England and the United States," *Am. J. Pub. Health*, 42:649, (June) 1952.
6. Byrd, Oliver E.: *Personal Health Inventory*. Stanford University Press, California, 1947. 8 pp. \$.15.

records, totaling the numbers of pupils with each defect, with defects treated, and the like, can better be done by a clerk.⁽¹⁾ The physician and nurse should each review the report before it is submitted to the superintendent for his review and signature. Copies of the summaries should be easily accessible throughout the following year to the health service staff in their own files.

When no trained clerical service is available and the nurse compiles the summaries, she will probably wish to have her figures checked by a second person if an adding machine is not used.

While it is desirable for its stimulating effect to have classroom and home room teachers report to the health service periodically the number and names of pupils with treated and untreated defects in their groups, no attempt should be made to get grand totals by adding the totals from these reports. Instead entries should be made on each pupil's record as his treatment is reported and verified. The final summary is then made from a direct count from the individual records, ensuring that each defect of a pupil is counted only once.

Various types of colored indicators are available from stationery supply houses. Attached to records and coded by color, letters, numbers, and positions on cards, almost any type of information which may be desired is made quickly available at any time throughout the year as well as for the annual report.

Reports to special groups. Statistical material gathered for the annual report furnishes a skeleton of facts and figures that may be used in preparing special reports for interested groups such as the board of education, faculty meetings, parent-teacher association, or other citizens' groups.⁽²⁾

When the physician is part time and the nurse is full time, the physician has a right to expect that a great deal of preliminary work on such projects should be done by the nurse.

Four 10-minute reports to a board of education, each centered around one phase of the annual report, for instance, are usually more effective than one 40-minute report. In preparing such a sectional report the statistical material may be amplified and specific illustrations may be incorporated to give it life.

Construction of the nurse's monthly report form. Attempts have been made with little success by various national and state agencies to develop report forms for general use. The reason is that the many variations in school nursing programs make it impossible to set up any one report form to suit all situations. It is much more satisfactory for the individual nurse (or the group of nurses when more than one is employed), with the advice of the medical supervisor and administrator, to develop a form which exactly meets local needs. Some nurses use no form but alter the statistical portion from month to month according to variations in the program.

Statistics. The statistical portion of such a report usually includes:

1. A table showing the number of pupils found with various defects or conditions which need attention, and a corresponding table to show the number who have received treatment or are under advisement. (This is always of special interest to the public.)

2. A section devoted to conferences:

Individual conferences including those with:

Pupils (readmissions, health advice, first aid, individual inspection, and the like)

Parents (at home, in school, by telephone, or other)

Only those are included in which something was discussed of sufficient significance so that an entry concerning it was made on the pupil's record or the information obtained was included in a report.

If the nurse is also the attendance supervisor, a report of her "attendance calls" will be desired for the attendance report. She finds it convenient to count her home calls under three classifications: (a) calls for attendance only—no health problems involved, (b) calls for health only—no attendance problems involved, and (c) calls involving problems of both health and attendance. Her report on school nursing will include the number of parent contacts at home made under classifications (b) and (c). The attendance report will include the calls made under (a) and (c). When problems of more than one child are discussed in one home each child discussed may be counted as one contact. If the nurse's car allowance is based on use of her own car in making home calls it may be wise to specify instances of duplicate calls in order to avoid possible criticism of padding reports. This can be done by stating the number of home calls and also the number of pupils whose problems were discussed in these visits.

In a report for the board of education more attention is paid to mechanical, technical, and administrative details, since members have the background to see their significance.

In a faculty report changes in procedure, comparison of results from one method with those obtained when a different method is used, and comparison of one year's statistics with another, are all of interest.

For parents or the tax-paying public too much detail is confusing, and it is better to place emphasis only on the basic purposes of the program with illustrations to explain general statements. Statistics are used sparingly and with careful explanation of their significance. Inclusion of material relative to the phases of the program which actually touch the lives of the people addressed will help ensure interest.

Some schools have found it valuable to send reports to local professional groups such as medical and dental societies, social workers' groups, council of churches, health committee of the council of social agencies, and others who are interested. In such instances a general basic report is prepared, supplemented with statistical or technical material of particular significance to the specific group. In all these reports emphasis on plans for the future and frank and objective appraisal of work which has and has not been accomplished make the reports more convincing and acceptable to readers.

Nurse's monthly report. A full-time nurse finds that a monthly report combining easily read narrative bolstered by well-selected statistics is one of the best ways by which she can keep her superintendent, principal, and board of education informed of her activities, her program, and the results. The report also serves her as a program guide to show her where her efforts have been directed and whether they need redirection. It may show points of over-emphasis or under-emphasis. It measures actual accomplishments against desired outcomes.

Changes due to the pressure of the times as well as those due to normal growth and expansion are also of interest. The report simultaneously provides excellent material for her administrator to use for publicity through the local press and other publications.

her work, for requesting additional nursing service, clerical services, changes in schedule, or improved arrangements for transportation.

Occasional time studies of routine activities, if properly planned and carried out, are of inestimable value in planning assignments and programs. Of course they may be carried to ridiculous extremes but this does not reflect upon their real value when properly done. In general, current time records or numerical counts are kept only on those activities which vary considerably from day to day, such as readmissions of pupils, first aid, home calls, and the like.⁽²⁾

The nurse usually prepares a large summary sheet for herself since no two nurses have the same duties from day to day. Following is a sample of the type of heading often used with, of course, plenty of space allowed for daily entries:

STATISTICAL SUMMARY FOR.....MONTH.....SCHOOL.....19..

(Activities, conferences etc. are listed below)	First Week	Second Week	Third Week	Fourth Week
	MTWTF	MTWTF	MTWTF	MTWTF

A nurse may prefer to put item headings in columns across the top of the page and use horizontal lines for daily entries.

Crosses or checks are put in indicated space as activities occur through the day. At the close of the day the numerical total may be entered in ink and pencil marks erased.

The form is kept as simple as possible and adapted to day, week, or month, whichever the nurse considers most convenient. The copy kept on the desk in the nurse's main office may have some headings which do not need to appear on those for her other schools. If she visits some schools only once or twice a week, or for only short calls, it may be easier not to use a desk sheet but to enter the items in her daybook or field notebook which she always carries with her.

Additional sections are often desirable. They may cover areas suggested below in "Emergency Information Reports." Some are appropriate for one month and some for another.

An analysis of the causes of illness absences for the month is always of interest and should be included if the administrator has

School personnel (principals, teachers, building superintendents, lunchroom employes, and others)

Family physicians and other specialists

Cooperating agencies (it is often desirable to specify certain agencies):

Regarding pupils

Referring cases not under school jurisdiction

Group conferences, including possibly those with:

Parents

Teachers

Pupils

Citizen groups

3. Another section including such activities:

Number of classroom groups inspected; observed; conferred with

Number of pupils given Snellen vision tests: in groups; individually; retested; color perception tests; muscle balance tests

Number of pupils given audiometer tests: in groups; retested; individual true tone tests

Number of pupils weighed; measured

Number of clinics at which nurse assisted

Number of pupils accompanied to clinics, physician's or dentist's offices

Number of pupils accompanied to homes

4. A section on activities related to public relations, possibly including:

Attendance at meetings concerning

Health

Education

Social work

Participation in parent-teacher meetings

Talks given to any group

Special programs prepared for assemblies or other groups

Form letters sent out

Printed bulletins distributed

Assistance given in preparation of articles for publicity

Any other contacts with the public regarding school health

Activity reports such as would be included in sections 2, 3 and 4 are possible only when the nurse keeps some type of a daily record, enabling her to give facts rather than guesses as to where her time has gone and what she has done. Definite data are necessary for making valid predictions of future needs, for planning

cial health department records. Two carbons are made. One is sent with the original to the health officer, and the second is kept in the health service file for reference if a question comes up later regarding the data transmitted—lot number, expiration date, and other information. They also supply data for making up totals for the annual report.

Request slips from parents for these services are filed and preserved for a year.

Each immunization given is recorded on the pupil's cumulative health record with the date. Each time immune reactions to vaccination are obtained they also are recorded.

Summaries of data from accident reports. These are effective both periodically and for special occasions. Presentations in graph form can be enlarged for posters. Comparison with previous reports and with reports from comparable schools add to the interest. The current edition of *Accident Facts*, published by the National Safety Council, can also be used for comparative purposes.

Emergency information report. This may be requested at any time by the director of the health service, superintendent, board of education, health department, parent or other citizen group. Such a report may concern sanitary or safety conditions, communicable disease (number of cases, number of contacts, number of immunes, time lost because of a certain disease, and the like), number of examinations completed, number of defects found, number under treatment, number of re-examinations, or examinations for working papers. It may be a report on the status of one of the special phases of the health program such as:

- Conservation of vision program
- Conservation of hearing program
- Tuberculosis case finding program
- Nutrition program
- Posture program
- Immunization program
- Safety program

arranged for gathering and summarizing required information. This may be in complete detail following the form shown in Chapter 12. For some months it may be abridged to show only the number of days lost because of illness in general, because of colds, and perhaps because of one or two communicable diseases of special importance at the time.⁽⁴⁾

Narrative section of report. Before beginning to write the narrative section the nurse determines in her own mind what is to be the climax, the thing concerning which she wishes to inspire action or the special concern of her medical director and administrator.

Effective development of the narrative section requires skill and imagination. This is prepared, of course, after the material has been compiled for the statistical sections of the report previously described. In the arrangement for presentation it may be effective to have the narrative open the report.

The narrative report is used to humanize the statistics which, while they show volume and trends, are to many people only cold facts and rather meaningless. It is used to portray activities and progress that cannot be measured in numbers alone.⁽⁵⁾ It allows discussion of unusual features, emergency problems, and special studies, and provides opportunity for emphasis on valuable accomplishments. If projected plans have not been realized there is opportunity to explain the reasons and to indicate further steps needed.

It reviews and previews. In most instances it is the narrative rather than the statistical report which sells the program to lay persons—and many board members are lay persons. Facts and figures appeal to a businessman, but interpretation is needed to bring out the whole picture of school health and the nurse's part in promoting and improving it. Just as the statistical section needs the interpretation of the narrative section, so the narrative section profits by reinforcement from the facts and figures of the statistical section.

Special clinic reports. Special forms are obtained from the health officer for reporting immunizations and vaccinations for offi-

summaries of materials on hand and requisitions of those which will be needed for the next period. If any unusual replacements are requested, or if there have been any excessive drains on the supplies, these are explained. Clerical, student, or adult help not only may be utilized for making an inventory but should be definitely arranged for. Professional supervision is needed for decision regarding discarding of drugs, and methods of packing away materials for preservation during the summer vacation.

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4. Eckhardt, Gertrude: "Better Annual Reports," *Nat. Tuberc. A. Bull.*, 38:21, 1952.
5. Yankauer, Alfred: "Designs for Evaluation Needed in the School Health Services Field," *Am. J. Pub. Health*, 42:655, (June) 1952.

To facilitate such special reports, the nurse tries to anticipate at the beginning of the year information that may be called for during the course of the year. Such items are then included when coding is developed, together with the use of the color indicator tabs referred to previously. Only in extreme instances will special files have to be established. These may be desirable for such groups as cardiacs, rheumatic fever cases, orthopedic cases, and vision and hearing cases when their handicaps are extreme.

Case report on an individual pupil or school employee. The nurse is frequently asked for a report, verbal or written, on an individual who may be having difficulties or about whom some question has arisen. In the case of a pupil, the problem may be difficulty in learning, a school behavior problem, or perhaps a court case because of family difficulties. The report may be presented to an individual, such as the teacher, school administrator, or children's court judge or court worker. It may be presented to a conference group, for the purpose of arriving at a plan for improving the pupil's situation or it may be presented to serve as a basis for discussion in an in-service education discussion, with administrators, teachers, and pupil personnel workers participating.

In the case of an employee the report may be requested because of consideration for a permanent appointment or for an illness leave. It may be needed because of a personality adjustment problem.

Review of information collected. Any record as something just to be filed is of no value. Its use as a tool with which to accomplish something must justify the time spent. No item of information should be collected which is not used, but the nurse must see remote as well as immediate possibilities, and the administrator's and teachers' uses as well as her own.

When a nurse has valuable information in her files that is not being used, she feels it her responsibility to seek an opportunity to present it for effective use. (See pages 228 and 327.) If no legitimate use appears, she may bring to the attention of her director, the possibility of discontinuance of the item on the records.

Report on equipment and supplies. Periodic reports, at least annually, on equipment and supplies are essential. Included are

Nurse's relationship to classroom teacher. No other single factor affects the accomplishments of a nurse's work in a school as directly as does the closeness, continuity, and harmony of her relationship to the teacher. It requires more planning, conferences, and mutual undertakings than any other of her relationships. To the teacher the nurse stands as a consultant on general health matters and policies and a source of authentic health information about pupils and their families. The nurse serves further as a resource for immediate and practical help when a health problem becomes too involved for the classroom teacher or requires too much time spent on an individual pupil at a sacrifice of the interests of her other pupils.

With secondary and elementary teachers, urban and rural teachers, well-trained and poorly prepared teachers, the nurse must develop such rapport that they will seek her for help regarding individual pupils, hygiene of environment, and for source material for health teaching.

Division of health service activities between nurse and classroom teacher. The primary function of a classroom teacher is the instruction of the group of pupils assigned to her. Since the earliest days of public schools in this country, and down to and including the present, there has been a constant struggle to free her from the many associated noninstructional responsibilities demanding her time and attention, in order to allow her opportunity to give the pupils instruction.⁽²⁾ The effort to do this has included development of such supplementary services as janitorial, clerical, and attendance.

Establishment of each supplementary service affects the teacher's activities. For instance, as schools change from a part-time janitorial service, of someone to shovel coal, carry ashes, and "sweep out," to an elaborate maintenance staff which may include engineers, sanitarians, and other specialists, there still remain certain important responsibilities the teacher must carry for her own classroom group, in relation to the hygiene of the individual pupil's environment. From these no variety or number of specialists can relieve her. A thermostat may automatically regulate the heat of the room, but it is the teacher who must see that the child does not keep his coat

Working with Teachers, Pupils, and Parents

When a public health nurse is working with a school child, his parent, or his teacher, she utilizes every possible opportunity to help that individual become more self-sufficient and less dependent upon her help. The nurse helps the parent and teacher still further to carry on with the child in her place whenever doing so is appropriate.

This is desirable for a number of reasons. Parent and teacher are already closer to the child, and their relationship is a more natural one. The next step, therefore, of having the child take over for himself is easier. The ability of teacher or parent to render services to the child gives him more protection than when he is dependent on the nurse, since parent and teacher are available to him for much more of the time than the nurse, and the service can be given more promptly. "Saving the nurse's time" is not a valid argument for having a certain service given by the parent or teacher as teacher time is equally valuable and parent time may be. But there is a real economy of time in service, when it can be rendered by a person already there, as compared with the time used if the nurse or other individual has "to be sent for." However, the first consideration in the choice of the individual to give a service to a child must always be determined by the values brought to the child. Administrative convenience must take second place and economy third.⁽¹⁾

and rubbers on in the schoolroom. The artificial light may be turned on and off as needed, by an artificial eye, but it is the teacher who must notice when a pupil assumes a position in which he will have poor light on his work. The seats may have been constructed in accordance with the best orthopedic principles, but without the teacher's intelligent, careful, and constant supervision the child may sit in the seat in an improper position. The most modern acoustic materials may have been used in the classroom, but only the teacher can see that the lip reader has the position in the group most helpful to him.

In a comparable manner even though the most complete and expert health service staff—physician, nurse, dental hygienist, audiometer technician, psychologist, and psychiatrist—may give their complete services to the pupils outside the classroom, there are nevertheless responsibilities for health supervision and services from which they cannot relieve the teacher. The members of the health service staff can do much to implement and make more effective the supervision the teacher gives by such things as supplying her with background information concerning each of her pupils, by helping her interpret what she observes about them, and especially by securing remedial action on health conditions which she discovers need attention.

Among the factors which must be given consideration in deciding whether a certain health service should be assigned to the classroom teacher are:

Is it something which can be done for the child as he is a member of his group more effectively than if he is separated from the others? Giving simple first aid for an injury received as he is in the group is an example which meets this requirement. He receives the aid more promptly and the experience can serve as good health teaching for the group. Giving a Snellen test is an activity which does not meet the requirement. For best results the pupil and tester should be alone and there is no advantage, rather a disadvantage, in allowing pupils to observe the tests of others.

Is preparing the teacher to do the activity effectively an economic use of her time and of the professional time needed for the training? Will she use the skill enough to justify the time required? Teaching her to

The third essential scheduled conference is one held near the end of the school year (or in a school where teachers' pupil groups are moved each semester, at the semester end). Again the pupils and their problems and progress are reviewed one by one and information shared. Pupils may be jointly interviewed in some instances.

Unplanned conferences. As unplanned conferences of teacher and nurse occur during the year, the work sheet is on the desk before them and entries are made as indicated. In some instances and especially if promotions are made more often than annually, it may be more convenient to use an individual classroom health card for each pupil rather than the one work sheet with all pupils' names on it. The same information is recorded on the individual card and the same teacher-nurse conferences held.

For plans for recording data assembled on the work sheet or health card, see chapter on recording (Chapter 14).

Group conferences with teachers. Individual conferences of nurse and teacher are very important and certain ones cannot be replaced by group conferences. There are, however, other instances when the nurse's time can be saved, and also the purpose served as well or even better, by a group conference. Among the latter are conferences to demonstrate and teach testing of vision and hearing, to give instructions involved in the installation of new record forms or in the inclusion of some new items on old forms, to give information concerning a current communicable disease or new regulations for control or preventive procedures. Each teacher profits by the point of view and questions brought up by others of the group. No more of the teacher's time is required than if the nurse instructed each individually, but a great deal of the nurse's time is saved. Another advantage, too, is the possibility of obtaining the help of specialists for a group meeting. The school physician or health officer may give the instruction on disease and disease control. State departments of education and health, state or local societies for the hard of hearing or prevention of blindness, or agents who have sold new equipment for the testing of vision or hearing—all may have representatives who will welcome the opportunity to partici-

The nurse reviews the information for use of the physician at the medical examination and, with the teacher, reviews the observations made by herself and the physician. The sheet is then left with the teacher.

As days go by the teacher enters additional information. The nurse, following parent contacts, discusses with the teacher information obtained and enters it in the proper column. These experiences with the nurse may help the teacher increase her ability to use the sheet effectively and to develop skill in recording significant observations, and the results of her own parent conferences.

Joint activities. The teacher shares other experiences with the nurse that may increase her ability to use the time she devotes to health work more effectively. Participation in the classroom health inspections is the classic example. (See Chapter 12.)

Allowing the teacher to accompany the nurse on carefully selected home calls offers other possibilities. Calls to secure follow-up for dental treatment may be a good choice. This is something on which teachers are usually already working. Seeing how the nurse approaches the parent on the problem and hearing her answers to questions, which are probably the same ones parents ask the teacher, may be helpful to her in discussing similar cases with other parents.

Planned conferences. With each teacher the nurse aims to arrange at least three scheduled and carefully planned conferences during the year, in addition to the many held informally because of special needs. A scheduled conference is held as soon after the opening of school as possible. The nurse brings the individual health records of the children of the teacher's group and discusses each pupil with her. At this conference also, in the case of a new teacher, she explains in detail the work sheet and gives illustrations of the type of material suitable for the column on "Teacher's Observations."

The second scheduled conference follows the physician's examinations of the teacher's pupils. It is better if the physician can have this conference with the teacher but if he cannot, the nurse is next best. Findings and recommendations listed on the work sheet are reviewed and explained.

be accomplished by teacher and nurse if a general over-all administrative plan to develop such integration is lacking.

Under any circumstances the nurse can bring to the teacher significant material from the pupil's health history kept during his elementary school life. She can contribute her knowledge of the pupil's family and home life. However, the pupil's "classroom teacher" is no longer one individual but has multiplied into four, five, or even more. This multiplicity of teachers is one of the outstanding difficulties the nurse encounters in following the child from the elementary into the secondary school. Since each of the several teachers has less opportunity to know each child than does the elementary teacher, the need for information from the nurse is intensified.

Another concomitant problem is this. Since each teacher has to teach instead of 20 to 30 pupils from 100 to 150, and in some types of schedules even more, there is a saturation point as to the amount of information about pupils she can absorb. Therefore in most secondary schools two different ways have been worked out by which this information from the school health service is made available to the instructional staff: (1) by lists of summarized information and (2) through case conferences.

On several lists (the total of which include the names of all pupils), certain pieces of information about individual pupils are summarized which should be known by all teachers who come in contact with them. These include such items as: should always wear glasses, color blind, slightly hard of hearing, no hearing in left ear, physical activity restricted, lame because of infantile paralysis in infancy, lame because of recent accident, lives in boarding home, lives with grandparents, works for board and room, diabetic, subject to skin allergies, under medical supervision because of anemia, and the like.

These may be circularized allowing each teacher to copy for her own record (preferably on her seating chart) the information about pupils in her classes or home room. If assignments to classes are made in such a way that a certain group of teachers work with a similar

pate. In demonstrations of testing, meetings held while school is in session allow the use of the actual testing situations in which the teacher will be functioning.

As the nurse learns to work effectively with groups she finds an increasing number of activities she can handle on that basis. For instance, she finds that, instead of preparing a certain piece of information or a list of treatment resources for a particular case or even for just one school, she can with little extra effort develop material which a number of teachers and perhaps several schools can use. Eventually she learns to go a step beyond this and utilize one teacher's skill and successful experience with a problem to help another teacher or a group of teachers who are facing it for the first time.

Orientation conference with new teachers. In a school which has a planned orientation program for new teachers, the nurse concentrates her efforts on having the health program effectively presented. If the school has no general plan, the nurse may ask for several conferences between the new teachers and the health staff with carefully outlined agenda for each.

Nurse and high school classroom teachers. (See also Chapter 22.) The basic relationship between the nurse and classroom teacher in the secondary school is the same as that with the elementary classroom teacher. It revolves around the needs of the child and mutual concern in helping him and his family solve his health problems in the most constructive manner. It goes further in order to help him develop a good body and proper functioning, help him take right and definite steps toward maturity when he as an individual is ready for the particular steps.

Nurse and teacher realize that neither alone can accomplish these ends. Each seeks information and help from the other. The two working together need the help of the physician and of other members of the school staff, and, most of all, a close teamwork with the family.

Integration of the high school health program with that of the elementary school is essential if results are to be effective. It cannot

found), this has not proved an effective plan. The intensive day-long association of pupil and classroom teacher in the elementary school which gives the teacher an intimate knowledge of the child is not repeated in the high school situation. The room teacher in the high school often has only a brief association with the child at a time when both she and he have many pressing routine concerns. She may or may not happen to have him in a class.

As a home room teacher is responsible for the pupil's attendance record, his excuses from home, and certain other duties specified in the local situation, the nurse does have occasion to consult her for information pertinent to many of the problems which come up.

Relationship to special health teacher in the high school. On both junior and senior high school levels, the nurse assists the health teacher in making and carrying out her plans for teaching units on personal inventories and personal health. The nurse furnishes data regarding individual health problems of pupils as well as any group problems indicated. As the work of these units progresses, the teacher refers pupils to the nurse for information and advice. As pupils develop their special projects of self-improvement, the nurse assists the teacher in evaluating their progress. Hereby the nurse is promoting her own program in the most effective way as well as helping to vitalize the school's health instruction program.

Plans are made for periodic conferences of health teacher and nurse throughout the period when the teacher is responsible for instruction. Since such a teacher does individual health counseling and also has parent conferences, pooling of information is valuable to both.

In the senior high school health teaching program, the nurse extends her participation to include sufficient teaching in a unit on health in the home, school, and community so that pupils wishing to do so may obtain the Red Cross certificate in home nursing. Any sacrifice the nurse must make of other activities in order to do this teaching is more than justified. This group of young men and women are not only to be parents of the next generation of school children but also voters who will or will not support the health programs of the school and other community agencies.

group of pupils, carbon copies may be indicated. For pupils with irregular schedules, a mimeographed list including all their names may be needed so that each teacher may have a copy.

There are always pupils for whom such impersonal information is insufficient. "Case conferences" attended by all the instructional staff for discussion of these children not only increase everyone's information concerning them but may be an effective method of staff education. (See Chapter 10.)

As a part of "final records" each teacher is asked to note on her class lists or on a supplementary list, if so arranged by the principal, items of information appropriate for incorporation in the pupil's cumulative health record. (See Chapter 14.) The number of such observations and their pertinency may be interpreted by the administrator as an indication of the teacher's concern with pupils as persons. He may utilize them in making his rating of the teacher's skill.

Conferences with secondary classroom teachers. The emphasis in the secondary school changes from that in the elementary school on individual conferences as the general procedure supplemented by group conferences, to group conferences supplemented by individual conferences. The individual conference is more apt to be sought by the teacher in the elementary situation, than by the teacher in the high school. There are two main reasons for this difference. In the elementary age group, problems are more self-evident and force themselves to the teacher's notice. Also, more attention to subject matter and less to child growth and development is often given in the preparation of secondary teachers than in the preparation of elementary teachers.

Conferences with home room teachers. There was a period in the development of health programs in the high school when it was thought possible to have the home room teacher assume the same relationship to the pupil which the elementary schoolteacher so generally assumes.

Except in unusual situations, and these are most apt to occur in small schools and in those where exceptionally well-prepared teachers have only small pupil loads (a combination not often

to guidance service with desired items specified by the guidance staff, the other for transfer of information from guidance to health service including items specified by the health staff. Another method is to have carbon copies made of pertinent material so that each staff member concerned may have a copy for his own files. (See page 401.)

Nurse and teacher of classes for the physically handicapped. Because of such a teacher's special preparation which includes a medical survey course in her field, she is unusually skilled in interpreting and utilizing medical information related to the specific handicap with which she is dealing.

Examinations by specialists are universally required for admission to a special class. In order to help the child, it is necessary for the teacher to know the diagnosis, prognosis, and special recommendations for each child. She must usually make special reports to obtain approval for the class and perhaps reimbursement from state or federal funds toward its maintenance. Since such reimbursement depends to a certain extent on the status of the pupils enrolled, very specific information is required. There is a reversal in these cases of the general principle that the school is concerned only with medical recommendations and not with the diagnosis.

General health services, such as measurement of hearing and of visual acuity, keeping of cumulative health records, medical examinations, and the like, provided for all pupils, are shared by the handicapped group as a matter of course and are the responsibility of the health service personnel.

Discussion of other features of the important relationship between nurse and teacher of the handicapped is found in Chapter 11.

Nurse's relationship to school librarian. The nurse works closely with the librarian in reviewing materials for supplementary reading on the elementary level and in assembling references for secondary health classes, for faculty use, and especially for vocational guidance in the nursing field.

They work together on conservation of vision projects. Some of these are carried on in the library itself. For those staged in other parts of the school, material is gathered for reference in the library,

Relationship to guidance director. Not only a "good relationship" but a practical working relationship between the nurse and guidance director or counselor is highly desirable. Each assists the other by exchange of information about the personal contact each has with the home through home visits and school conferences with parents. In aiding the individual whose achievement or adjustment is adversely affected by irregular attendance, disposition, mood, manners, appearance, personal hygiene, and speech, the counselor relies heavily on information supplied him by the health service and especially that accumulated by the nurse. On the other hand, the counselor is in an advantageous position to call the attention of the nurse, physician, psychiatrist, speech correctionist, or other staff member to tendencies toward unusual behavior, deviations from normal reactions, and irregularities of physical or mental make-up directly or indirectly attributable to a physical defect. To provide for this needed exchange of information, regularly scheduled meetings of guidance director and nurse are useful.

In addition to information exchanged by word of mouth, exchange is facilitated and often stimulated by use of special forms developed for the purpose and routinely used.

Counselors find frequent need to invite health specialists to case conferences. Their aid in diagnosing problems and interpreting factual data presented is invaluable at times. If health records supplied by the nurse are consulted when assembling case histories for psychiatric case conferences.

As part of the procedure in applying for employment certificates, the placement officer and health service arrange jointly for the medical examination. The health service keeps a record of all examinations and of permits issued on a temporary basis because of physical reasons. Special supervision is then given to secure needed treatment before the expiration date.

Definite plans are required for care and filing of information of mutual use to the two services, health and guidance, if such sharing is to be effective and economical. When use of the same records proves impractical in a certain situation, the provision of two simple forms may help—one for transfer of information from health service

to develop improved eating habits. She may find students who would like part-time work in the school cafeteria. She assists, like the home economics teacher, in maintenance of high standards of health and cleanliness for pupils and employees working in the school kitchen and dining rooms.

Personal hygiene problems, family problems, and school health problems are brought to the surface in home economics classes. The teacher may be helped in dealing with them if the nurse shares with her information gained in home visits and from the health records. Again, the nurse may obtain equally valuable assistance if the teacher shares information she has gained through class discussion and home visits.

The teacher often asks the nurse to give demonstrations in home nursing, child care, and first aid as it is taught in the home economics classes. A nurse should give as much assistance as her program will allow as it helps to strengthen the accomplishments of both health and home economics programs.

The health teaching which is included in the broadened home economics field can be utilized to raise family and community health standards, as, for instance, in immunization practices.

Nurse and physical education teacher. When a school physician is not available, generally the nurse, physical education teacher, or a private physician is summoned in major emergencies. In some situations it is desirable for the school physician, nurse, and physical education teacher to work together to develop more detailed instructions for the care of particular emergencies. For example, the physical education teacher requires advice as to procedures to use in his athletic activities carried on away from the school. Though his instructions may be in greater detail, they are kept consistent with the principles used in establishing the general first-aid instructions.

Both the physical education teacher and the nurse are concerned with general health, recreation, rest period, and modified physical education programs. The two departments work together in corrective physical education, examination of feet, evaluation of posture, investigation of excuses from physical education, and in prevention

for utilization for displays there and elsewhere, and for background information.

The librarian keeps the nurse informed of new material in the nurse's field which comes to the library through professional sources. She may obtain reference materials on special subjects for the nurse from a state or other medical library. The nurse may request specific books, periodicals, or articles, or if she knows of no particular reference but needs information on a certain subject, she may make a general request for any materials available. She includes a statement of the purpose for which the information is to be used—for the nurse's own information, for a talk to a group of mothers, for a nurses' meeting, or for high school students. The librarian can then select the material to be sent on an appropriate level. This can better be done through the librarian than by the nurse directly as the librarian has the proper forms and knows the procedures to follow in applying to another library for material.

Health posters of current interest may be displayed in the library as they will attract the attention of more pupils than when used in the health room only. To secure the librarian's approval the nurse will find they must be attractive and timely.

Additional attention is directed to graphic presentations of health surveys and studies made by the health service staff or by groups of pupils, if copies are posted in the library as well as in health and classrooms.

An alert librarian may detect mild behavior problems from observing a pupil's choice of reading or his conduct in the library. She may be able to give valuable information in case studies and to bring into use some of the therapeutic value of selected reading.

Nurse and home economics teacher. These two workers share many common interests. Both make home visits. Both are concerned with choice of diet and eating habits of children at home and in school. Both participate in development of general policies for the school feeding program.

The nurse may be asked to help select children for supplemental lunches and to decide which children should receive free food or milk. The nurse may also suggest pupils who need special attention

cept of what is involved in a successful interview. One such experience is working with child guidance clinics and joining in the psychiatrist's conference following his examination of a pupil. Familiarity with mental tests given by the psychologist (of that staff or of the school staff), considered as a "highly standardized interview," may help her develop an objective attitude in her own interviewing. Nurses in school work have long felt the need of taking additional courses in the three fields named above and also some of those offered in guidance, counseling, tests and measurements, and social work.

It is of interest that the greater the nurse's knowledge becomes in these areas, the more she feels the possibility of still greater development of skill in interviewing. It is the unprepared and inexperienced nurse who is apt to be too easily satisfied with an inferior ability. As with development of skill in any activity, practice alone does not make perfect. There must be a constant comparison of actual achievement with a high standard of performance. Since in many school situations there is little nursing supervision available to assist the nurse in such evaluation and in methods for improvement, establishment of procedures to cultivate her powers in this line may rest entirely on the nurse herself. It is that nurse for whom this has been written. This is an area in which improvement will enrich the nurse's other professional activities and her personal life as well.

In school situations there are many interviews which are one of a continuing series; often they are simple, direct, and related to a single item. They may be concerned with obtaining, or giving information, from or to administrators, teachers, pupils, parents, or cooperating agencies. The ease and success with which they are handled will be influenced greatly by the skill with which preceding and especially the first interviews were made.

The first interview. The importance of a first interview is further heightened when it is to be the only one, as is too often the case for a specialized school nurse with a very heavy pupil load or for a generalized nurse whose program includes a limited amount of school service. In such instances the majority of her interviews

of epidemics of fungus skin infections due to poor sanitation, especially in shower rooms and swimming pool premises.

In preparation for corrective physical education, either the nurse or the teacher accompanies the children to the physician or the diagnostic clinic. Information secured is used by both services.

Many schools schedule examinations of high school students by physical education classes, enabling the teacher to participate in the examination and to record for his own use information useful in the development of his own program. His presence is particularly desirable during examination of candidates for competitive sports. The physician can then explain to him directly the significance of defects found and reasons for modifications ordered (See Chapter 18.)

Nurse and elementary and special subject supervisors. The more adept a nurse is in recognizing opportunities to obtain assistance from these highly trained people, the more effective and attractive the health program becomes. Of course she is equally generous in participating in projects with health implications initiated by such supervisors.

*The nurse as an interviewer.** Of all the various activities in which a nurse doing school work engages probably none consumes more of her time than interviewing. There are few for which she has had less preparation. Most of her functions in the school health program involve these "conversations with a purpose."

Often she has received little formal instruction in interviewing, and she finds it her personal responsibility to develop skill in it. Her previous experience in a profession—nursing—in which human relations and contacts are of uppermost importance, gives her a unique background upon which to build. In her preparation for public health nursing, courses in psychology, sociology, and mental hygiene have enriched the perspective she needs to develop this special skill. Work in which she participates as a member of the school health team provides experience which she can utilize to broaden her con-

* This paragraph and material through end of the chapter from "The Interview in School Nursing," by Marie Swanson, *Public Health Nursing*, April, May, 1949.

"Taking the words out of his mouth" is insulting. It may also be disconcerting since there is always the possibility she may be wrong in thinking she knows what he wants to say and she may further increase his sense of frustration instead of helping.

While a nice air of informality is usually an asset in an interview, a punctiliousness in identifying oneself as a person and as an official, and explaining one's connection with the situation, is vital. The latter is just as essential when interviewing a pupil, even a very young one in school, as when interviewing a parent one has never met before, if the pupil is to be prevented from feeling he is being pushed around by forces outside himself. When making a first home call a formal self-introduction by name and title, with presentation of a professional card, is in order. Parents and pupils alike are most generous in their interpretation of acceptable reasons for a nurse's concern with their affairs. Teachers, administrators, and workers in other professional agencies are less likely to assume a reason and expect it to be definitely stated. As soon as the nurse becomes personally known to parents and pupils, her justification is often taken for granted without statement, if the first association has been satisfactory in this respect.

In any interview the nurse must recognize that she is being interviewed as well as interviewing. Giving the person, unobtrusively, an opportunity to do this to his satisfaction clears the way for him to give his attention in the direction desired. It is rare that an individual has just one problem—the one we are concerned with at the moment. He is apt to have an assortment. If he wants the nurse's consideration of the one which to him seems very important right then, some discussion of it may well precede an examination of the matter for which the nurse sought the interview. Of course in an interview sought by the parent ordinary politeness ensures thorough consideration of his purposes before the nurse uses the opportunity to bring in some items she has had in mind. More time may be required, but the danger of having an undesirable cross-examination type of interview is reduced.

There may even be instances when the nurse does not bring up

with both pupils and parents regarding treatment of illnesses and defects and to secure improvement in health practices may have to stand alone. This means that in the course of just one conversation, with a parent for instance, the nurse must obtain information from him concerning his understanding of the child's condition, his attitude toward the problem, and additional information concerning the actual condition of the child to supplement what the school already possesses. She must give the parent information which the school has but which he lacks, and perhaps help plan what to do about the matter. She must also, if the interview is to accomplish its object, be sure that the parent understands that the nurse is a sincere person who can be trusted to put the child's welfare above other considerations; who understands the parent's problems that may have prevented him from doing all that ought to have been done for the child previously; and who respects the parent's desire and capacity, with help, to shoulder the responsibility for obtaining what his child needs. There must be no doubt in the parent's mind that the nurse will guard the confidentiality of any personal information given.

Formality and informality. In all her interviews with parents, and with pupils as well, the nurse looks for opportunities to counteract the impression of impersonality which always threatens when an organization such as the school she is representing deals with problems of individuals. It is necessary to show eager interest without inquisitiveness, receptivity without personal curiosity, sympathetic understanding without pity, calmness without superciliousness, approval without patronizing flattery, and serenity without indifference. Of course in a single interview it will be impossible for her to understand a person, his attitudes, his problems, and his desires completely, but it is important for her to show him that she *wants* to do this.

When the nurse interviews a parent or a child who seems nervous or incoherent, she may be tempted to rush ahead and try to express his ideas for him. She must encourage him to take his time to state in his own way and his own words what he is thinking and feeling.

her original reason for the visit. If she finds the family involved in a more acute emergency, she realizes she could well prejudice her cause rather than further it.

Establishing one's position. Of the many important aspects of a first interview with a parent or child there is none more vital than that he realize that the nurse's purpose is to serve as an adviser to him in his solving of his problems. This is an impression directly opposite that given by the nurse whose philosophy is, "My school calls? Oh, they're easy. I just tell them what the school says they have to do. They are used to trying to do what the school expects of them. They're no trouble!"

A first interview with a member of the school staff may be equally decisive in determining the character of future associations with that individual. Her first interview with the administrator may precede her actual employment, or her assignment to the particular school. Whether she intends it or not, he will obtain as early as possible, or try to deduce from the conversation, an idea of what she thinks is his place in relation to her and her work. By direct statement or by obvious implication, early in their discussion, she can assure him of her proper understanding of his administrative responsibility for her school activities, her use of her time, teacher's time, and pupils' time, as well as for representation of the school and its policies in the community. It may be undesirable at this time to discuss details of the way in which it can be accomplished, but it is never too early for her to refer to the necessity for his being fully informed at all times regarding her plans as well as her activities, and supplied with up-to-the-minute information concerning health situations in his school.

In the case of a new school physician coming into the school, or a new nurse joining a staff with an established physician, similar assurances may be in order, though often there is less need, as each assumes the usual professional physician-nurse relationship will exist. The first interview may not be the best occasion for stating the many exceptions that may be necessitated, especially if the physician is part time and the nurse full time.

A first interview with a teacher may be entirely social in nature.

or with the wrong bystanders, may give an administrator, teacher, child, or parent an aggrieved sense of "being put on the spot." At best it may stimulate a snap decision. For the one-item-of-a-series interview, the appointment is often of a scheduled type. With administrators and teachers certain periods are scheduled at the greatest convenience of both parties, at which times matters of certain nature will be taken up. With pupils and parents, the time for the next conference, which may be a simple report type, may well have been set at the previous conference, either as a specific date or "after such or such has been done or has happened."

As previously mentioned, the tone of these one-of-a-series interviews is greatly influenced by the tone of the initial one. But no matter how fine that was, since no relationship between two people ever stands still and either grows better or worse with the passage of time, its preservation merits some attention.

Appointments with parents for interviews at school, allow the nurse to choose a time when interruptions will be at a minimum. A sign on the door "disturb only for an emergency then knock" is justified. Unexpected entrances are disconcerting. Provision of a really comfortable chair and removal of wraps are indicated. If the nurse is already familiar with the home situation or if it is not especially significant in relation to the matter to be discussed, the parent conference at school has many advantages over the nurse's home call. Its whole atmosphere is different. The parent who might have felt on the defensive in a home conference has now worked through that reaction by taking the positive action of coming to the school. There is no feeling of being at a disadvantage because of a disordered house, informal clothing, or household interruptions. If the interview is held in a room with partial partitions, assurance should be given that others are not behind them.

Evening appointments, preceding or following a PTA meeting, community meeting, or other program, allow a conference with both parents. Definite appointments should be sought as some parents might not wish to confer at such a time.

A school conference at which a school physician, principal, or

have the same vocabulary, native intelligence, educational, social, or racial background.

Opening the interview with ordinary everyday conversation gives the nurse an opportunity to feel out the individual's ability to understand. She early learns to distinguish between illiteracy and lack of intellect.

• *Interviewing to get information.* Whenever possible, facts are obtained from records rather than through interviews. They are more reliable. The nurse's time is saved and she is showing a respect for the time and patience of the other person. However, a request for information may serve as the stated reason for an interview designed for another purpose but one, if introduced too abruptly, might arouse too much emotion or antagonism. Specific questions are delayed until as much of the information as possible has been obtained through spontaneous conversation. When direct questions must be asked, they are put in nontechnical simple language and asked without hesitancy or apology and with no suggestion of embarrassment.⁽⁷⁾

Questioning the accuracy of any statement or requesting substantiating evidence is delayed until a final summary. It is then presented in a noncritical and matter-of-fact manner. The nurse recognizes that inaccuracies may be due to unwillingness, prejudice, ignorance, inarticulateness, and perhaps most frequently to a misunderstanding of what is desired. Inevitably some distortions appear, from a desire to please or from self-interest. Many inconsistencies are irrelevant and may be ignored.

Interviewing to give information. This may seem to be the "easiest" type of interview, but in one way it is more difficult than the process of obtaining information. In the latter case, it is easy to know that one has or has not obtained it. In giving information, skill is needed to determine whether or not the person has understood and accepted the information.⁽⁸⁾

The nurse's words often mean something very different to the parent or child from what they mean to the nurse. Sometimes his hearing is faulty, and he covers up his lack of understanding. Until he gives back some evidence that the ideas did get across to him,

tions, an offer to leave and return later "when I can see you alone" or "when you are not so busy" may suggest removal of some of the confusion elements.

Collecting background information for a nurse-parent conference. If the interview is to be concerned with some medical specialty such as diabetes, rheumatic fever, epilepsy, appendicitis, or allergy, the nurse may wish to refresh her memory by a review of the subject in a good pediatrics textbook,⁽⁶⁾ and the current pamphlet material in her files. Having in mind all possibilities allows her to explore more effectively, to establish the exact situation in the special case. Her knowledge and understanding increase the previous confidence in her and in her advice.

Sometimes information should be obtained from the child as to any recent changes in the problem or in the home situation or concerning action they may have taken on the problem. The child's health record and that of his siblings are reviewed. If a family folder is kept that is checked. If the situation warrants it, a check may be made with the Social Service Exchange or if there is none, with the particular cooperating agencies that might be concerned.

Almost invariably the teacher of the pupil should be consulted. Checking may be indicated with the teachers of siblings, the principal, attendance worker, visiting teacher, and others. If siblings are in schools served by other nurses, and if there is no system of circulating or cross-filing of interview reports, the nurse may check with her fellow nurses for a double purpose—to obtain information from them and to give them an opportunity to tell her of anything they would like to have included in her interview if opportunity allows. Of course, if she has had previous interviews with the parents, she reviews the records.

Outlining what is to be done. In her own mind or on paper the nurse outlines what is to be included in the interview. The main purpose of this is to clarify her own thinking on the matter. It is not to create an outline of procedure which she will necessarily follow. Questions to be asked are not definitely formulated, but the points they must cover are strictly defined. Forms of the questions must be varied to fit the individuals encountered, no two of whom

types of situations and experiences," they are usually based on a definite personal experience.

Some attitudes are hard to change because they are based on a deep emotional involvement. Others in which less feeling will be aroused are more easily modified. Unless the nurse begins at the point where the individual is in his thinking, her chance of bringing him to the desired point of view is lessened. When she knows what the experience was which determined his attitude toward the present situation, she has an opportunity to supply data which may help to counteract the previous experience.

Since an attitude toward a situation is determined less by its intrinsic merit than by its relation to the individual's personal interests as he sees them, the nurse may wish to help him see more clearly the direction in which his personal interests lie. What parent's life will not be made more comfortable if his child is ill less often? The nurse may either help him promote his own interests as he sees them, or when indicated she may precede this by helping him see his own interests differently. Her information and experience in health matters often enable her to point out factors and possible outcomes which have not previously occurred to him and which will show him new potential effects on his personal interests.⁽⁹⁾

When surgery is indicated and parents hesitate, there are three frequent reasons—fear of operations, the considerable expense, doubt that such drastic action is necessary. The direct questions, "Are you afraid, do you hate to spend the money, or do you think it isn't necessary?" might fail to bring out the true reason. Words are used to conceal as many attitudes as they disclose. An informal discussion of tentative plans for arrangements, such as "If you should decide later to do it, where would you be most apt to go for it?" might give more clues as to the real attitude than a direct question. Almost any topic which will keep him talking in the desired area is worth trying. Telling about other cases, with some points of similarity or dissimilarity known to the parents, may serve the purpose. If fear is found back of an attitude, the person may be shown that possible results of no action are really more fearful

one cannot regard the interview as completed. Having him repeat verbatim words said gives no assurance of understanding. A more subtle method of checking is necessary.

A person who wants information receives it more readily, keeps it longer, and is more apt to use it than one who feels no need for it and receives it passively. Before giving a person, whether parent or pupil, information the nurse feels he should have, she considers the matter from his point of view and how he might use it. An endeavor to lead him to feel the need and request the information, instead of giving it to him gratuitously, is worth the extra effort involved.

A nurse may be asked to give information she does not have. Perhaps it is information she should be able to supply. She arranges to secure and send it in the most convenient way to the person desiring it. Perhaps it is information for which the nurse is not responsible but what she could secure. Before deciding to do so she should answer these questions. Should the person have this information? If so, will it be more valuable for him to get it for himself? Can the nurse afford the time to secure it for him?

When it relates to a subject to which the nurse has given no previous consideration, she may say so and that she will see what she can find out. She need not be apologetic. There may be occasions when the opportunity to say "I do not know" may be an asset in demonstrating one's frankness and sincerity.

Interviewing to secure a change of attitude. Such interviews require the most careful approach, the most cautious handling. They are the most difficult on which to evaluate progress. To this problem—change of attitude, the nurse may apply the procedures she has seen used in medical practice. She seeks a diagnosis before she plans treatment. She studies the situation through listening to the person talk on this and related topics, in order to learn *what* his attitude is and as far as possible to learn *why* it exists. If she can help the person recognize his own attitude and analyze the reason for it, she may have helped him take an effective first step toward changing it. Although attitudes are "standardized reactions in given

help the parent make plans for him. She may find, however, that before she can take up the child's problem she must help the parent, as a troubled human being. Even allowing him to blow off steam, to tell his troubles to her, may be a valuable contribution to his welfare and happiness. When this is insufficient, referral to his family physician, spiritual adviser, or to an official of an appropriate cooperating agency may be indicated.

The nurse wants the parent to feel she considers him an equal with whom she can exchange information, ideas, and opinions. She asks a question or introduces a topic which will bring up something in which he can have pride. When he does talk, she listens for a point which can be related to the purpose of the interview.

When the conversation does get down to the child, some parents ask advice of the nurse before she is ready to give it. Authoritarian advice is avoided, as people seldom take it. What is desired is to help the person develop a healthy attitude of responsibility and of self-confidence in his ability to handle the situation himself. She may avoid answering his request for advice by asking him questions along the same line which will help him view all sides of the problem. She may supplement his information, or help him think through what outcomes can be expected from various possible modes of procedure. The nurse learns to accept parents' attitudes of anxiety or resentment toward her with the same objectivity with which she accepts those of dependency or gratitude.⁽¹⁰⁾

When a parent cries during an interview it is usually better to go on with the discussion with a sympathetic but matter-of-fact attitude as if such behavior is not especially surprising. This helps the parent accept his own feelings and regain self-control.

Even in those rare instances when force of the law must be evoked (as in communicable disease control or attendance matters) the nurse makes it clear that she and the school staff are all subject to the law, which was set up neither by her nor by the board of education. The nurse helps parents to feel that she and other school personnel are employed by them and their neighbors to protect their children and all children, and that the laws in question were passed by the people of their state for the same purpose.

than those of action. If the reason is financial, it may be shown that no action is apt to prove eventually more expensive than desired action.

Need for security is one of the strongest emotions in determining attitudes. The nurse can utilize it appropriately for urging practically all health habit improvements and treatment of many types of defects.

While ordinarily attitudes change slowly, in time of emergency and emotional stress, the individual is more vulnerable to change. This is one reason why in school nursing work one never marks a case closed nor despairs of ultimate success, no matter how discouraging a situation. Keeping in touch with the child, the family, or the teacher, the nurse is ready to step in when some element in the situation changes. It may be a misfortune or good fortune; no job or a better job; removal to a new neighborhood; and addition to or a subtraction from the family group; a school promotion or a failure.

When a nurse makes a suggestion to a parent for a change in his child's behavior, it may be done in such a way that the parent feels criticized by the very necessity for the suggestion. Or it may be done in such a way that he not only retains his self-respect but even feels complimented that the nurse seeks his help. Sympathetic understanding of another's problem contributes to establishment of a good partnership relationship; pity has a sting which causes the individual toward whom it is directed to lose stature with himself. Whether dealing with pupils, parents, or teachers, the nurse's contacts should build up the person, to himself, not tear him down. The nurse may get a clue for a means of changing an undesirable habit if she discovers how or why it was set up in the first place. This is apt to be particularly valuable in nail biting when often the cause has vanished long since, and the biting is continuing only because attention has not been drawn to it. The nail biter's and not the nurse's understanding of the original cause is the vital point and may be all that is needed.

The nurse may have arranged an interview with a parent in order to find a key to a child's problem, to obtain data about him, or to

interview, the child must be made welcome as a person. Whatever the nurse's attitude may be (or must be in some instances) toward his behavior, she makes him feel her consideration for him as an individual apart from what may be undesirable behavior. When necessary she delays examination of matters charged with emotional conflict until some rapport has been established. When the amount of nursing service in the school is liberal enough so that she and the child are already known to each other through working together on vision testing, getting ready for the doctor's examination, and conferences after absences, the necessary rapport is usually already established. He knows her as someone who has an honest concern with him and his problems and who will give him help. On this basis an intimate and confidential relationship can be built up quickly.

Unfortunately, it is possible that the manner in which routine interviews with pupils are handled by the nurse may set up a barrier between them instead of laying a foundation for satisfactory rapport. Situations in which the nurse must deal abruptly and hurriedly with individuals in the presence of other children, with part of her attention given to keeping order in the on-pressing group, should be eliminated.

To avoid such incidents, schedules may be established so that not all teachers send pupils to the health room at the same moment. Pupils can be taught to line up single file (with the line extending as far into the corridor as necessary) and to stop at an indicated distance from the nurse so that she and the pupil she is interviewing may have a degree of privacy.

At intervals it is valuable for the nurse to take stock of the routine interviews she is having and consider if some of them could be eliminated through setting up other procedures. Having a nurse see a child unless she takes time to give him some individual consideration may be a waste of his time, his teacher's, and the nurse's time with no purpose served. A nurse needs to spend enough time with a child to allow her nursing judgment a chance to function. *Otherwise any other more convenient individual might better "pass"*

Specific questions concerning amount of income, rent paid, and similar matters are seldom warranted in a school interview since the school does not engage in relief activities, but refers indicated cases to relief organizations. The nurse may tell the parent something of the eligibility required in order to guide him when making his decision in regard to applying for help.

There are many occasions when the services of the nurse, if dealing with persons of superior intelligence, may be limited to helping secure a recognition of the problem. She may perhaps also give some assistance in outlining the sort of plan that might be made to meet it. The individual may know so much more about resources and possible procedures than does the nurse that it is unnecessary for her to continue in the picture while he makes his decision and completes his plan.

Interviewing pupils. Children have a greater tendency than teachers, parents, or other adults to color their statements in accordance with what they think the nurse would like them to say. They are also apt to be more sensitive to her attitude toward them and if they distrust her or feel she distrusts them, they are more likely to withhold information. Evasion, hesitation, and misrepresentation convey a great deal to a nurse who has an intent and ability to understand what is signified. Assistance to the child in understanding his own mind may result in his straightening out some of the conflicts causing the confusion, and may prove more valuable than the original purpose of the interview.

Scheduling pupil interviews. An uninterrupted time and absolute privacy for interviews with pupils when certain problems are involved are as essential as in interviews with parents.

When the interview has been sought by the pupil or when it is one of the continuing series with a good relationship already existing, no delay in getting to the point is indicated. But if pressure has been used to secure the interview—"Go see the nurse"—or if improper behavior of the pupil is the reason for it, it is well worth the time and effort required to give him some evidences of personal interest, respect, and courtesy. Regardless of the occasion for the

In a pupil interview, the nurse may give the pupil a card with a note of the time when he is to return. It may happen that when an interview is "finished" because tension is relaxed, some of the most revealing items may then come out, which may have been considered too trivial or irrelevant to be mentioned earlier.

When there is difficulty in obtaining the objective of an interview, it may be wise to establish a good relationship and leave the way open for future contacts. An attempt to force on him advice or action he is not yet ready to accept may not only fail but may also make subsequent progress impossible.

Subsequent interviews. In these, the introduction usually resolves around what has happened in the interim. The parent has an opportunity to ask questions about things not clear, recalled from the previous interview, or which have come up since. The nurse has an opportunity to use that principle of learning—repetition—in a graceful way to emphasize the most important features of any previous instruction. The parent who finds it hard to accept new ideas has had time to become accustomed to a "startling" proposal and may be ready to move forward a little further.

Recording an interview. Not all interviews need to be recorded. Each should be counted, however, since a nurse needs to know where her time has gone. Only an instant is required to make a mark under the proper items on the daily report blank on her desk pad or in her travel notebook. In the case of a parent interview there is value in knowing there has been a contact even if no progress was made. At least a brief notation should be made—perhaps on the pupil's cumulative record—specifying date, which parent, problem considered, "no progress," and if possible the reason for no progress. Of course when progress was made there is no question of the value of recording the interview describing the progress made.

If no notes were made during the interview, it is essential to make them before beginning the next one. A good interviewer has a good memory. The nurse finds that with resolution and practice she can greatly increase her ability to remember what she wishes to record. But her record cannot be trusted as implicitly if made

on him. An unpleasant experience when the nurse may seem to be indifferent to the pupil hampers the development of good relationship later.

Funny situations and little jokes are enjoyed by most children. However, referral to the nurse is apt to seem to a child a much more serious occasion than it is from the nurse's point of view. Therefore flippant and facetious comments, so many of which are above the child's level, are poor practice. Children do make serious statements which are almost irresistibly funny to adults. While the nurse may control properly her own reaction, other adults or older children present may be less considerate. In such cases the nurse courteously explains to the child so he can laugh too.

Having a certain, though perhaps quite limited, time periodically when pupils have an easy informal access to the nurse contributes to the development of a real rapport. Serious, though brief, consideration of a pupil's minor problems paves the way for opportunities to help him when more important situations arise. With a few exceptions, each interview which a nurse has with a child is an opportunity to do mental hygiene teaching through guiding him toward establishment of desirable emotional attitudes toward things which happen to him and toward people with whom he associates. She helps him understand his relationships with his teachers and with other children, and his ever-changing relationship with his parents. She helps him develop a good attitude toward the rights of others and a sense of responsibility for the welfare of others.

The highest type of nurse-pupil interview is the one in which the pupil voluntarily uses the nurse as a consultant in making a decision of his own.

Closing an interview. Before concluding an interview the nurse may have the individual make a summary to be sure there is mutual understanding of what has been discussed. Then together they plan the next steps, focusing on immediate procedures though including distant goals as well. Each specifies what he is to do before the next contact, and together they decide whether that contact will be by letter, telephone, through the pupil, or by another interview.

question. Use of a well-constructed form cuts down the amount of writing required. The form for obtaining history preceding a child's acceptance at a mental hygiene clinic is one illustration of this. Some nurses construct simple forms for a certain type of call, as eye defect, illness absence, animal bite, or others. An occasional run of carbon copies keeps her supplied.

When a person sees a record made of what he is telling there is increased need for assurance as to the interviewer's reliability and respect for all confidences given. Too little respect is sometimes shown. School staffs need a type of in-service staff education program to develop professional ethics similar to that carried on among physician and nurse staffs and similarly supplemented by disciplinary action when infractions occur.

It is a temptation to a nurse with skill in story telling to capitalize for their entertainment value some of the more striking incidents she encounters. This stimulates repetition of the stories by teachers, using them as conversational material, "Have you heard the latest about the family?" Usually the nurse can find a less spectacular episode to illustrate a certain attitude of which the teacher should be informed.

When used to illustrate reports or to liven a speech, all identifying data must be modified and the story accompanied by a statement that this has been done, as otherwise enterprising minds will find a family on which to fasten it, and though it may be the wrong family, injury may result.

As mentioned above, in some instances no record of an interview needs to be made, but in complicated situations the nurse may wish to write not only a full record of an interview for her own file, but may find it valuable to dictate selections from this, of which carbons may be made for others concerned with the family—other nurses, the attendance supervisor, the pupil's teacher, or the teacher of siblings. In some instances carbons of the entire report, suitable for one worker to have, might not be desirable to give out to others. For the "average" case one record to go on the pupil's health record or into the family folder or the child's guidance folder is all that is necessary.

made any plans about treatment?" is preferable to "What plans have you made?" If the answer to the first question is "yes," usually the parent will go on with details. If not, the nurse can ask, "Will you please write me a note about it so we can have it for our files."

When deciding whether to make a telephone call instead of a home call, it is not enough for the nurse to put herself in the place of the parent and decide, "I wouldn't mind discussing that on the phone if it were my child." She must remember that her professional point of view on health matters is very different from that of many lay people and develop in herself a consciousness of possible sensitivities of others.

Interviewing a feeble-minded person. While a slow process, some information can be obtained or given, and especially attitudes can be influenced, if the I.Q. is not below 50. This is possible only when the nurse is patient, chooses simple words, carefully repeats over and over, allows as much time as is desired for each separate idea, and is sensitive to the person's reactions as expressed in any way, not relying just on his response in words.

As are some others, the feeble-minded are extremely suggestible, so unusual care must be used when information is being sought, not to suggest answers by the form of the questions, facial expression, or tone of voice. Since they will naturally be reticent to give information until they feel confidence in the nurse and really accept some reason why she should be told these things, the nurse is unusually careful in her explanation. The full reason may be inexplicable to such an individual. As in other interviews, the judgment used in proper adaptation of scientific material to the level of the person interviewed, with his prejudices, interests and needs kept in mind, determines success or failure.

Using an interpreter. When a parent has a language difficulty, the nurse must decide whether there is more to lose or to gain in using an interpreter. The caliber of interpreter available may be the determining factor. If it must be a child of the family who may be inept in conveying what is meant or who may even have purposes of his own in distorting the conversation, a postponement of the interview until a time when another adult who does speak English

Interviewing by telephone. It is preferable for the parent to call the nurse than vice versa, as the nurse is then assured that the parent has no objection to discussing affairs over the telephone. Those accustomed to a private line think of a telephone conversation as being personal and confidential. Those who use party lines, especially in rural areas where identities of the subscribers are well known to one another, are apt to feel differently.

When the nurse must use the telephone in the school office, she must be sensitive to the lack of privacy and most discreet in her choice of problems to be discussed. Her statements must be guarded when there is any possibility of being overheard or if the parent fears they may be. Some parents feel it a violation of their privacy to have others know they were advised to have a physician. Some would not want a certain neighbor to hear discussion of a clinic appointment.

It is worth while for school administrator, school physician, nurse, and teacher to make definite, concentrated, planned efforts to encourage parents to develop the habit of calling the school to volunteer information when their children are ill at home or when plans are to be made for treatment of defects, or to obtain health information. It takes less time to be called than to call and it ensures that the parent has no objection to a telephone conversation. Just as the parent coming to the school for a conference indicates an advance beyond the situation where the school must seek out the parent, so the parent's telephone call to the school indicates a desirable initiative on his part.

When the nurse does call a parent whose attitude toward such calls is still undetermined, she may open the conversation with a question that allows the parent to give little or much in reply. For instance, in the case of an illness absence, instead of asking, "Now just what is the matter with him?" one may say, "I hope he is not very sick" or "When do you think he will be coming back?" This gives the parent the privilege of just answering the question or, as most of them are glad to do, of telling the nurse all about the child's condition and asking her advice.

In calling about treatment of defects, the question "Have you

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may be home is one solution. Use of a teacher as an interpreter adds dignity to the interview and makes it easier to help the parent accept the nurse and the school as allies in securing the best obtainable for the pupil. The teacher also often has much of value to contribute directly. Also some foreign-born people have a greater respect for members of the teaching profession than for members of the nursing profession.

Interviews in the course of school nursing are usually for the purpose of obtaining information, giving information, or to try to help a person change his attitude on a particular problem.

Improving one's ability to interview. At the conclusion of an interview with a pupil, ask oneself: Was the interview an active or a passive experience for the pupil? Was he left with the feeling he had settled his problem or at least knew what next step he should consider? Is his feeling of responsibility for his own health increased or lessened?

Following an interview with a parent one may ask: Did I find out what the parents really thought about the problem? Did they feel I really knew what I was talking about? Was my information scientific and up to date, and interpreted so it was meaningful to the parents?

At the conclusion of an interview the nurse had sought, did the individual feel the time expended was worth while? Was the person who had sought the interview with the nurse satisfied that adequate consideration had been given to his problems as he saw them?

If one wishes to improve interviewing skill, it is well, after each interview to take a moment to review the original purpose and evaluate progress toward that end and any additional accomplishments. The nurse working in school situations can find opportunities to observe, as a nonparticipant, skilled interviewers in action. She can be sensitive to successful (or unsuccessful) methods of interviewing which others use on her and to her own reaction to certain techniques. She can read and re-read professional articles or reference books on interviewing in various fields—counseling, social work, psychiatry, business, and research, as well as in nursing.

PART V

Working in Special Situations

Working with Children in Nursery and Elementary Schools

Entering the school world. Children begin their school lives via the nursery school, the kindergarten, or the first grade. Only a few have the advantage of nursery school though the number is increasing; a too small number have a chance to attend kindergarten. As one who understands the benefits these educational experiences give children, the nurse may help develop a public appreciation of their values and encourage their organization in school systems which lack them.

The child's readiness. The nurse's judgment may be of value in helping parents and teachers decide whether a certain child is ready to enter school. There was a time when "ready to enter school" implied merely a chronological age, measured not only in years and months but definitely to the day, with remediable defects corrected and specified immunizations given. It is now recognized that there are many other vital factors to be considered in determining readiness. Arrangements can be made to satisfy some of these requirements; others can be met only by allowing the child additional time to develop the requisite maturity. To help parents understand the needs of the child at this stage of his life and improve their ability to help him, some schools provide a special publication to parents

will make him feel that people do care about him, want to understand him, and help him to do interesting things.

In either case, to attain the end desired the school people must know a great deal about each child. The nurse gets or takes part in planning to get a careful history of each child, including pertinent information about his family background. Such a history must include social and emotional information as well as physical since it is impossible to understand needs in any one of the three areas without consideration of the other two. (See Chapters 12 and 14.)

Preschool examination. The effective work done in many parts of the country by parent-teacher associations in securing examinations for all entering children has resulted in values beyond those accruing from the correction of defects found in the examinations. Stress has been placed on performing the examination a considerable time before the child's entrance into school and in the family physician's office rather than in the school. A better examination can be given by the family doctor with the proper space and equipment and with desirable emphasis on it as a family affair rather than as a school procedure. There is another advantage—it avoids having what may be the child's first school experience a tiring one, or at least boring, as he waits his turn, or goes through what to him may be unpleasant. There may be the added strain of booster immunizations or perhaps even long overdue original ones.

Vision and hearing testing. When these tests first became part of the school health program, it was customary to postpone testing a child until he was in the third or fourth grade so that he was "easy to test." Now it is realized that with properly prepared testers it is possible to get reliable results even from very young children. Also, there is a constantly increasing appreciation of the fact that giving the tests before the child enters school is important for his personality development as well as for his successful educational progress. As is true of the medical examination, there is general agreement that, whether he makes his school entrance through nursery school, kindergarten, or first grade, the preliminary examination and tests are more essential then than at any other time in his school career. If the school program can insist upon them only

of children indicated on the census register as belonging to the age group concerned. State departments of education and health also have pertinent and useful materials for distribution.

If neither are available, the nurse may wish to obtain *Preparing Your Child for School*,⁽¹⁾ published by the U.S. Office of Education. As supplementary material, there are excellent chapters in *The Nursery School* ⁽²⁾ and *How to Help Your Child in School*.⁽³⁾

The parents' part in preparing the child. School experts stress the absence of advantage in parents attempting to anticipate the type of teaching which the school is set up to do, such as teaching the child to read before he enters school. Rather the home's part centers around learnings of another sort and of great importance. Each child needs to have had physical experiences sufficient in amount and variety so that his muscle coordination gives him good balance and use of his body with poise. He needs to have learned to go to the toilet alone, wash his hands and face, put his wraps on and off, and take care of other personal requirements. Such fundamental health habits should have been taught him as keeping his fingers and other objects out of his mouth, nose, eyes, and ears; covering sneezes and coughs; drinking only drinking water and eating only food given him for that purpose. Preparatory to his learning to read, his parents can allow him generous opportunities for self-expression, telling his thoughts and describing his everyday experiences, not just to his mother or to one person at a time but to the whole family. They can help him learn to use new words and understand new concepts by discussing them with him and by reading aloud to him. Replacement of "baby" terms to describe his body processes by those generally used will help his social poise as well as his vocabulary.

The nurse may find some parents who need help in meeting their own problems of adjustment to the child's growing up.

The school's part. For the fortunate child who has had love, patience, and understanding in his home circle keeping him in tune with the world about him, the school aims to provide a place that will continue this for him. For the less fortunate child who has not had a happy home, the school aims to provide an experience that

of the school staff may be his neighbors or friends of his family. He may have "visited" on certain occasions when especially invited and planned for. He may have played with the fascinating toys in the kindergarten, eaten tasty food in the lunchroom, and experimented with the playground equipment.

For another child the school may be an unknown fearsome place. His friends may have had unfortunate experiences with teachers or fellow pupils. For such a child the nurse may help plan and carry out a program for his easy and gradual adjustment to a strange new world, as it is especially important that his own first experiences be happy and reassuring.

It may be possible to arrange several informal visits, if not with a parent then with an older brother or sister who remains within call while the child gets acquainted with his teacher and some of the children. If this is not possible perhaps an older neighbor child may go with him.

The nurse may be able to call on his family before school opens and, while she is getting his own and the family history, make it a point to get acquainted with him. Then when he comes to school he will recognize at least one familiar face. It will be a comfort to him that there is one person who knows him, knows where his family lives, and to whom he is already a special individual.

In some schools the entering group attend only mornings for a period long enough so the teacher can use the afternoons to call on parents who have not come to the school to get acquainted.

Often the entrance into school of the oldest child in a family is the first contact the parents have had with an elementary school since they attended one themselves. They are apt to assume the situation is the same now as when they were pupils. Even if, as rarely happens, the child attends school in the actual building they did, the school itself, usually physically, and certainly in its management and organization, is quite different from what it was a generation previously. The nurse may have a part in stimulating them to discover what the child's school is like so they will be better able to help him adjust to it.

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It is true that it takes more time and skill to test a five-year-old than a ten-year-old. But early testing is really a timesaver when it is considered what might be lost in the intervening period by the child with an undiscovered vision or hearing difficulty. Add to this a teacher's time lost trying to teach such a child and the frustration and confusion of both child and teacher. The child's personality damage because he does not understand why he cannot do at all what his classmates seem to do so easily may be more serious even than his educational retardation.

Since few physicians include such functional tests when examining young children, tests are usually a school health service function even when medical examinations are given by family physicians. A well-trained team is required and the teacher of the child's group is the key member, both because of her special skills in working with a child of that age and because she and the child know each other. Assistants may be adult volunteers or perhaps members of a high school class in child care or other high school students. Students may be considered preferable to volunteers because of their greater availability. If adult volunteers are used, only those who can give a definite and large amount of time and who are already known for dependability will justify the amount of time required to prepare them for the work.

There are three secrets of success in testing such young children—a pleasant patience on the part of the tester, letting a group of the children play with the equipment a number of times before testing them, and an ability to read the child's reaction from his expression and actions rather than dependence on his words. These apply to both vision and hearing testing. (See Chapter 9.)

Orientation. Not much formal planning may be needed for orientation in the case of the child who is part of a stable, respected family in a well-run community, with good schools in which older children of his family or of neighboring families have had happy successful experiences of which the entering child has heard. He may already be familiar with the physical plant of the school. Some

his own. A current immunization table may be obtained from the health department.

It is usually undesirable to have an inflexible requirement that every excluded child must be seen by a physician before readmission, as there may be a large number of these occasions and on some of them it is quickly obvious that the child is all right. There are other occasions when he is not excluded but when he should be seen by his physician, so it is better to make referrals to the physician on an individual basis rather than by set rules and regulations.

Nurse conferences with parents and teachers. In carrying out its function of parental education the nursery school finds the nurse a valuable participant in conferences on growth and development of children with groups of staff members and parents and also with individual parents and teachers. When the parent cannot come to the school or when additional information about the family or home situation is needed there are instances when a home call by the nurse may be more effective than by a teacher.

The nurse's part in the guidance program of the elementary school. A nurse who understands the aims and methods of individual guidance—health, personal, educational, and vocational—can actively stimulate effective guidance by classroom teachers for children in their early school years. In professional literature much more is said and written about "Guidance Programs" in secondary schools, where it is supplied by specialists, than about the guidance function in the elementary grades. This does not reflect the comparative importance of guidance to the two groups of pupils; it may even be that the needs are being better met in the earlier years so not so much needs to be said. Davis says: ". . . well nigh one hundred percent of elementary schools have no professionally trained counselors capable of taking leadership in a pupil personnel program." (4)

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When formal inspection is omitted the child is individually greeted by the nurse or an experienced teacher, looked at, and the guardian asked to describe variation from normal in appearance or behavior which the child may have shown since he was last in the school. This implies that the school must have ascertained definitely that the parent is an observant one who notices his child carefully, notes variations, and has regard for the danger to his own child and other children if his child is allowed in school when he should not be there.

The end of the nursery school day. If she has time the nurse finds it profitable to be available again as the children are leaving. While some mothers are hurrying home to get the next meal started, other mothers and often the fathers are in a more relaxed mood than in the morning and ready for a more leisurely discussion of the child and his progress. Just as the school wants the parent to share his information concerning the child with the school, so the school should give the parent information accumulated from the child's experiences in the school that might be helpful to the parent's understanding and management of his child.

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family emotional situation, the child's own emotional reactions, and many other possible contributing factors.

If a child must be automatically excluded because there are indications that he is "upset," some of the beneficial values of the nursery school may be denied him. If his upset is the result of family tension, he may need the stabilizing effect of the school at that time; family tension may be further increased by the problem of what to do with him when he is excluded.

On the other hand, if the school overlooks the child who should be excluded, then discovers after the guardian has left that the child should not remain in school, the problem may be difficult for the school to handle if the child comes from a family where there is no one at home during the school session. In the case of a school with ample facilities, caring for the child in a room by himself until the usual time he is taken home may be arranged. This means a generous number of staff members must always be available and may be too expensive to be practical.

Another solution may be that the school requires each parent to designate a home to which the child may be taken if there is an emergency and the parent is not accessible. When "working mothers" are involved the school sometimes assists in locating such homes by advertising for volunteers to offer such help as a community service. Because of the possibility that the child may be coming down with a communicable disease, homes with young children are not suitable and the appeal is made to the "grandmother" group. In some cases it has been grandfathers who have responded. Although the school may properly take part in stimulating community interest in the matter and in collecting names and addresses of volunteers, actual arrangements for such care are made directly with the volunteers by the parents. This prevents difficulties which might develop if the school takes responsibility for an activity it is not in a position to supervise.

Replacement of formal inspection by parental education. In a well-organized school with an effective parent education program, it may be unnecessary always to have a formal inspection which the child must pass before he is readmitted to the group. Inspection is

Parent-school rapport. Parents should develop the feeling that they and the school are going to work together to give the child his best chance to grow happily and to develop into the finest person it is possible for him to become. Without special effort on the part of nurse and other staff some parents are unhappily on the defensive and expect the school to "blame" them for shortcomings the child may show. Or they may be too ready to blame the school for difficulties the child may encounter. Life becomes easier and pleasanter for the child, his parents, and the school people as well, when parents realize that the members of the school staff expect normal children to have difficulties, plan to work with the children and their parents to eliminate problems, and take this as part of the usual plan of work. (See Chapter 12.)

Working in the nursery school. When the amount of direct service a nurse can give in a school system is limited, priority is usually given to the nursery school. Even a short period if assigned at the most critical time of the day may pay big returns in preventive and educational values.

Inspection on arrival. Among the most crucial are the fifteen to thirty minutes when the children are arriving at the school. A correct decision as to whether a child is in condition to remain in school is more essential in the case of small children than with older ones. The decision is also more difficult to make, both because of the child's lesser ability to express his subjective feelings and because of his greater sensitivity to external influences. Generally speaking nursery school teachers are better informed concerning typical childhood illnesses than other teachers but even so they cannot be expected to have the nurse's fund of information nor to have developed a comparable medical judgment. Anyone can learn to read a thermometer and follow a schedule of excluding for a temperature above a certain set figure.

However, fever is only one of the many possible significant indications which should be considered. There is special value in the nurse's skill in interpreting variations from the usual, in the light of such things as the kind of a night the child had, his supper the night before, his attitude toward his breakfast this morning, any

his own. A current immunization table may be obtained from the health department.

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Medical supervision. Rather than set up elaborate services in the school it is preferable for the nursery school to utilize recommendations from the family's own medical consultant—private practitioner or clinic—and to encourage parents to have the necessary examinations and immunizations outside the school. If there are children for whom this is impossible the school might better provide services than let them go without. Certain services are essential if the child is to mingle with other children, for their safety as well as

Using the Secondary School to Extend Public Health into the Community

Special health problems in secondary schools. We might be tempted to think this age group the healthiest of all age groups because its death rate is lowest. The physical status of these pupils, however, is inferior in many respects to that of elementary children. Vision defects are twice as numerous; heart and lung conditions increase as the group moves toward maturity; tuberculosis after accidents becomes the first cause of death. Thyroid conditions appear. Skin conditions are more prevalent. Constipation, indigestion, and appendicitis are more bothersome. Personality difficulties increase—the rate of admissions to mental hospitals increases from 4 in the 10- to 14-year group per 100,000 population to 40 in the 14- to 19-year group. Psychic trauma may result from variations in metabolism. The rates of drug addiction, suicide, alcoholism, and venereal diseases all begin their upward climb during this period.

The zigzag pattern of the adolescent's growth confuses him, his parents, and his teachers alike. There is no orderly list of processes through which his physical, intellectual, and emotional growth may be expected to pass, since neither the time he will enter this period nor the rate at which he will move through it are predictable. All individuals involved including himself, therefore, find it difficult to say what will happen next.

given these teachers, and more recently that given elementary teachers in general, has emphasized development of skills along these lines though the term "individual guidance" has not always been used. No matter how skilled the teachers are in giving such guidance, they are limited in what they can do for the child by the extent and depth of their knowledge of the child and his family situation. The nurse shares with them her knowledge of the child—his physical status, his family, what is happening to him outside the school, and what has happened to him in the years before the teacher knew him. The greater the skill possessed by teachers in giving guidance, the more valuable is the use they can make of information made available to them by a well-organized pupil personnel service.

Value of the elementary record of the child to secondary school guidance. The nurse's own contributions to this record enrich it for guidance purposes in high school years. Assistance she gives the classroom teachers in recognizing and recording pertinent material, beyond that customarily recorded, may pay big returns.

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As progress is made in securing adequate nursing time for school health services, high school nursing programs are moving into the preventive field.

Pupil's responsibility for his own health. In the high school this is the first emphasis made by physician, teacher, and guidance worker as well as by the nurse. As the years elapse between entrance to junior high and graduation from senior high school, the amount of work done directly with the pupil rather than through the parent is steadily increased. This does not imply that the parent becomes less important, for there must still be effective teamwork between the school and parent or there will be waste motion and poor results. It does mean that the parent and school can work together through the medium of the pupil, instead of over his head, as it were.

Today's secondary school gives the pupil as many opportunities as possible to assume responsibility for his own health and to learn to make wise decisions on health matters. The school endeavors also to have programs, schedules, and procedures set up in such a way that the pupil is encouraged to form health habits and health attitudes that are based on the world's best scientific knowledge of health, disease, and personality development. At the same time attitudes of responsibility for the health and welfare of others are fostered. None of these accomplishments is easily achieved. Frequently forces outside and inside the school seem to be pulling in opposite directions, rather than moving along parallel and desirable lines.

The health program of the secondary school is more than health supervision, physical education, and health teaching. It is the sum total of all the health forces within and without the school.

One has only to look at the complexity of the average secondary school curriculum to understand why effort is necessary to keep health foremost in the thinking of administrators, school personnel, pupils, and parents. During this period of life young people are

Certain established facts emphasize the need for careful and adequate health supervision *in and out of the secondary school*. Physical defects, nutritional lacks, and unhygienic habits of living are not only serious in their direct effects on the physical organism but *magnify and complicate emotional upsets*. Even when the body is sound physically, difficulties may be encountered in getting it to function efficiently. Medical consultant service for some of the special problems involved are lacking in so many areas there is special need for the nursing service to help such pupils secure treatment. Even more important than remedial measures, however, is the positive, constructive guidance required to help the adolescent child progress toward maturity.

On the whole parents have been better educated to understand the problems of infancy than of adolescence. The nurse's help is especially appreciated by parents of this age group.

Amount of nursing service in high schools. Except in large high schools employing a nurse or nurses exclusively for school work, few statistics are available as to the amount of nursing service given to this age group.

When nursing service available for a school system is limited, the usual practice is to give nursing care to the younger groups at the expense of the older ones. This is not because the services nurses could give to the secondary schools pupils are less significant than those given to children in the elementary schools but rather because of two other factors. One is the traditional pattern. Nurses first came into the schools because of communicable disease. Incidence is greater in the younger groups; therefore it was for the younger children that most of the nursing work was first carried on. The other reason is the usual one found tragically often in all our health programs. Needs rising from neglect are more obvious and insistent than provisions for prevention. Even though the actual cost of prevention in the long run is much less than the cost would be to the public, individuals, and families of caring for conditions resulting from neglect, our programs usually busy themselves with corrections and treatments at the expense of more forward-looking activities designed for prevention. It is hard to look at a small needy

child entering school and say, "We will ignore you in order to have time to work with potential parents now in high school so that their children will be healthier and so that they will vote funds for necessary protection for all children."

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being prepared to take over the self-direction of their lives. They must be guided in such a way that they will acquire an appreciation of the essentials of healthful living, and know how and when to seek and use the right kind of professional care and how to avoid health hazards.

In order to fit herself into this picture and to be able to recognize and meet the problems of adolescence, the high school nurse must know and promote the practice of the basic principles of adolescent psychology. She must understand the physical, mental, emotional, and social needs of the adolescent and the adjustments which need to be made by him and for him. She needs this high competence in order to carry out her own work and help parents when they seem unable to cope with teen-age problems.

The nurse in the high school keeps in mind individual differences in development of the adolescent. She realizes that the many aspects of such development are the results of heredity and environment and she takes into consideration each pupil's background. She knows that at this age the drive to be with the group is pronounced. She is aware of differences which may set the individual apart from the group. The fact that he is too fat or too tall or too short is of major importance to him.

Early or delayed maturation of boys or girls may also present a problem. Voice changes in boys, figure changes in girls, and awkwardness of both as a result of rapid development cause embarrassment to the adolescent. Through guidance at this period much can be done to help boys and girls realize that change is a part of growing up.

The obese pupil under sympathetic guidance based on medical advice can be helped to lose the right amount of weight. The pupil who has grown overly tall may improve his posture if he realizes that a well-chosen diet will help fill out his rapidly developing bony structure.

vantage can be minimized or in some cases even utilized to advantage.

She helps to interest the pupil in his own well-being and gives him a feeling of responsibility for maintenance of the best possible health. She makes him feel her sincere interest in his problems. She assists the family in understanding their adolescent child, including the physical and emotional changes which he is experiencing.

There is a prevailing idea that high school pupils, because they are older, do not require the supervision that elementary school children need. It is true they do not require the same type of supervision. Even though communicable diseases, for instance, are not as prevalent in the high school age group, the need is insistent for individual guidance and assistance in meeting growth and personality problems.

The program of the nurse in the high school, whether she is full time or part time, includes the general activities that have already been discussed. Participation in the health examination and in follow-up for treatment of defects are important parts of her work as are measures to prevent and control communicable diseases. She may again be given responsibility for investigation of illness absences and readmission of returning pupils. Parent conferences are just as important though usually less frequent than for younger age children. Individual pupil conferences are even more important. Conferences with other members of the faculty are as much needed as in the elementary school though often for different types of problems.

If the student council has a health committee the nurse works closely with it to build student interest and participation in the health program.

Helpful mechanics of operation. Preparation of a set of pupil schedule cards for the nurse may be a problem. In some schools these are prepared for the health service when they are made for the general office and in the same manner. In other instances copies are made by a clerk or by student assistants. The first method is preferred as it obviates delay. This is important because the cards

are essential in planning and carrying out her work from the first. They are used in scheduling all appointments—for medical examinations, individual vision and hearing tests, and for conferences with the physician or nurse regarding such activities as follow-up, pupil's absences, or absences of younger brothers and sisters.

The nurse should not have to depend upon using the schedule cards in the main office as this causes many delays and takes too much of her time. Often inconvenience to clerk or principal is involved as well, since the nurse may interfere with their use of the cards. (See Chapter 14.)

Pupil-assigned responsibilities. The nurse's use of a squad of high school pupil assistants may prove desirable for a number of reasons. The health room should never be left unattended and may be manned by one of the squad. With facilities of the health service always available there is greater utilization of first-aid equipment and rest cots. The nurse's time is freed for more professional duties. As they become familiar with the nurse's schedule pupil aides can make tentative appointments for students who wish to see the nurse when she returns.

Assignment to the health room offers the aides an opportunity to develop poise and ability in meeting and handling people. They learn to accept responsibility. In choosing the squad, the administrator, nurse, school physician, counselor, and teachers may consider possible candidates who need help in solving their own personal problems or who need vocational guidance. Use of pupil assistants helps the nurse to become more familiar not only with these individuals but with the general characteristics of the age group with which she is working. Care should be taken to select pupils whose present schedule is not overburdened. Some schools make the selection early in the fall, and the squad continues throughout the year. In larger schools members may be changed periodically.

With proper instruction and careful supervision pupils may be responsible for the physical equipment of the health room in the nurse's absence. They are not allowed to accept any responsibility for first aid. In her absence a member of the school staff, usually a classroom teacher, principal, or his secretary, accompanies the

injured pupil to the health room and is responsible. This procedure makes it convenient and efficient to have the health room always open, with first-aid supplies easily available, and a pupil present who is familiar with the equipment and details of first-aid records.

When a pupil with an emergency problem comes in not accompanied by a staff member, the pupil aide in charge reports to the principal's office for instructions. Pupil aides do not handle confidential records such as pupil health records. (See Chapter 13.)

In a large school it is wise to assign two aides in the busy period of the day, such as the half-hour before school opens, the first period of the morning, or the first period of the afternoon. These periods are usually crowded due to readmissions, reinspections, and individual pupil problems, but may allow a few last-minute arrangements for physical examinations or other details which need attention. Pupil aides can deliver messages and save time for the nurse as well as increase the general efficiency of the health service.

It is advantageous to have a pupil on duty for a half-hour period after school because the health room can then be put in order, first-aid supplies checked, and any special preparations made for the morning schedule. During examinations, tests, clinics, and certain other activities, more than one pupil may be used at a time, but in the regular schedule, except at periods mentioned above, it is better to have only one. Pupils use these periods for study when they are not busy.

Pupil aides receive preliminary instruction which covers policies regarding appointments with the nurse; use of daily records and reports; use of rest cots; appointments and preparation for special tests, that is, examinations for athletics, examinations for working certificates, preparations for physical examinations; answering the telephone; recording announcements of the public address system and location of all teacher personnel.

One pupil is placed in charge of the squad, making the pupil aide program more businesslike and interesting. Through this leader, arrangements for substitution in case of absenteeism are made. He may be appointed, or may be selected by the group. As each successive group of pupils enters the work there will be a tendency

are essential in planning and carrying out her work from the first. They are used in scheduling all appointments—for medical examinations, individual vision and hearing tests, and for conferences with the physician or nurse regarding such activities as follow-up, pupil's absences, or absences of younger brothers and sisters.

The nurse should not have to depend upon using the schedule cards in the main office as this causes many delays and takes too much of her time. Often inconvenience to clerk or principal is involved as well, since the nurse may interfere with their use of the cards. (See Chapter 14.)

Pupil-assigned responsibilities. The nurse's use of a squad of high school pupil assistants may prove desirable for a number of reasons. The health room should never be left unattended and may be manned by one of the squad. With facilities of the health service always available there is greater utilization of first-aid equipment and rest cots. The nurse's time is freed for more professional duties. As they become familiar with the nurse's schedule pupil aides can make tentative appointments for students who wish to see the nurse when she returns.

Assignment to the health room offers the aides an opportunity to develop poise and ability in meeting and handling people. They learn to accept responsibility. In choosing the squad, the administrator, nurse, school physician, counselor, and teachers may consider possible candidates who need help in solving their own personal problems or who need vocational guidance. Use of pupil assistants helps the nurse to become more familiar not only with these individuals but with the general characteristics of the age group with which she is working. Care should be taken to select pupils whose present schedule is not overburdened. Some schools make the selection early in the fall, and the squad continues throughout the year. In larger schools members may be changed periodically.

With proper instruction and careful supervision pupils may be responsible for the physical equipment of the health room in the nurse's absence. They are not allowed to accept any responsibility for first aid. In her absence a member of the school staff, usually a classroom teacher, principal, or his secretary, accompanies the

cal education equipment is convenient for the actual examination procedures. (See Chapter 8.)

Another plan is the free period appointment. It takes more time and is more applicable where there is a full-time high school nurse. This system is sometimes preferred by administrators and teachers because they feel there is less disruption of class schedules and less pupil time lost from class. The plan does work efficiently on the day of examination but requires more preliminary planning than the first method described.

Weighing and measuring. If in the elementary grades pupils have become accustomed to a periodic check of growth and development, with an increasing emphasis on their own participation in the actual weighing, measuring, and recording, they can keep their own monthly records of weight during high school with comparatively little teacher supervision.

Cards made out for periodic weighing and measuring may be placed in a small file near the scales. The home room teacher checks the cards periodically to remind pupils who have failed to fill in their records. She instructs pupils to remove outside wraps, shoes, and other heavy garments so that the weight will be consistent. She notes any losses or any peculiar gains, and those pupils who have failed to gain for several months. The teacher reports these pupils to the nurse, who in turn may refer them for further examination by the school or family physician.

Notation for special supervision is made on the cards of pupils for whom the school or family physician requests such supervision. Arrangements are made for them to report periodically to the health service. The nurse works to secure regulation of diet, exercise, and rest through conferences with pupils, parents, and teachers. In case of children with borderline nutritional conditions the nurse may further assist by making inquiries about health habits followed at home. She also continues to keep in mind the correction of minor nutritional deficiencies and faulty dietary habits reported for other pupils.

When the nurse hesitates to approach a pupil or parent because of a suspected case of tuberculosis, pregnancy, or glandular im-

to formulate better policies concerning assignments and for pupils to take part more freely in the development of the program.

In her preliminary instructions to them the nurse informs the aides that occasionally she may wish to have private conferences. She may have a certain phrase she will use to indicate this, such as "Will you see if the librarian has any new material for me?" The pupil will understand that he is to leave and return when the conference is ended.

The pupil assistant method is effective when developed properly but it must have established administrative procedures if pupils are to accept responsibility and make the program a success. (See Chapter 6.)

Readmission after illness. This is of great importance in high school since many modifications of individual programs, including physical education as well as general, are necessary. Opportunity for health teaching of pupils seeking readmission is especially important. By making studies of absence records the nurse may interest teachers and pupils in improving attendance and in reducing Monday morning absences. Such studies can be brought before the student body through use of bulletin boards, assembly programs, student council, school paper, or local newspapers. Realization of irregularity of habit as a cause of this type of absence helps to reduce the number of absentees as well as to give valuable health teaching of a practical kind. (See Chapters 12 and 13.)

Planning health examination schedules. The physician, nurse, dean, principal, or an official he designates, such as the guidance director or secretary, will plan examination schedules so there will be as little interference as possible with instruction schedules.

Sometimes this is most easily achieved by scheduling the pupils while in English or physical education classes. Considerable time is saved for all concerned because these two classes take in the entire high school registration, and through one or the other, there is a reasonable certainty that all will be examined. Another advantage is the clerical assistance the teacher may offer. If it is the physical education teacher, he will be especially interested in the physician's findings for the physical education record. Some physi-

is most important as a preventive measure. When the services of a social worker or visiting teacher are not available the nurse gives valuable help by making home calls to find the contributing factors in social and emotional maladjustment. (See Chapter 11.)

Nurse and health guidance. Health guidance is so closely associated with educational and vocational guidance that the general counselor, dean, or guidance teacher and the nurse have a natural opportunity for close cooperation.

In schools which have a guidance department the nurse participates in that program by helping in the compilation of case histories. Collection of health data properly has begun in the elementary school and continued throughout the school life of the pupil. With the full history available to her the nurse contributes and interprets health information gained from pupil and parent interviews, health records, and medical examinations and tests. In some schools joint records are kept, and in others a notation on the health record or guidance record shows where the original record is filed. Child guidance clinic records should be accessible to both health and guidance services.⁽¹⁾

The nurse has a special responsibility in aiding with problems of vocational adjustment and placement when the pupil has permanent physical handicaps which may be more or less disabling or need special consideration. Color perception tests have particular significance for vocational guidance in the high school age group. If there is any doubt about a color test that has been given earlier during the school life of the pupil it should be repeated and interpreted in the high school period. The procedure can be facilitated if tests are explained to a group of pupils, preceding individual tests. This age group needs even closer supervision of the use of the eyes than do younger pupils. Defects of vision increase rapidly as the pupil progresses in school and is called upon to do more close work. He is sometimes heedless of where and how he does it. A study made in 1939 of 24,000 New York State high school students showed that the percentage of pupils wearing glasses in grades 9, 10, 11 and 12 were as follows:

room during a free period. In this way she has more opportunity to consider the pupil's appearance, interest, stability, and general character. She tries to discover where the individual's real interest lies and determines if it is an interest strong enough to withstand some possible disillusionment, and if it is a realistic viewpoint rather than an exaggerated idea of the glamour of nursing.

The nurse might point out the different specializations in nursing, the opportunities for professional advancement, variation of employment policies, and hazards. To girls she emphasizes the fact that nursing education prepares any girl to take the responsibilities of the woman role in life more efficiently.

The nurse helps prospective applicants for nursing plan to overcome any handicaps such as acne, poor nutrition, bad posture, body odor, poor grooming, and personality difficulties. She takes into consideration the pupil's scholastic potentialities when she discusses with him or her the possible choice of one of the three current nursing education programs—the hospital school of nursing, the collegiate nursing course, and the practical nursing program. The nurse refers the interested pupil as early as possible to the guidance director or the teacher to whom the guidance program has been assigned, because that individual has the responsibility of mapping the high school course of study to meet entrance requirements for a school of nursing.

For this same reason the nurse works closely with the guidance director in compilation of a file of up-to-date material which will include information regarding the accreditation of various schools of nursing, requirements for entrance, and books and pamphlets on the different specialized types of nursing. The guidance folder should contain the latest issue of any state publication on nursing schools. Current information and advice can be obtained from counselors on recruitment in the National League for Nursing, 2 Park Avenue, New York City, and from the nurse's own state league for nursing. These two organizations will furnish material that may be instrumental in attracting good candidates into the nursing profession.

The guidance director often plans field trips for pupils who have expressed an interest in different occupations. The nurse may be

9	10	11	12
11%	13.1%	13.7%	13.3%

When no guidance counselor is provided the nurse works closely with the principal and teacher who are concerned with the pupil whose program is being adjusted. Hazards connected with shopwork and experiments in the science laboratory intensify the need for better protection of eyes, such as adequate lighting, use of goggles, care of eye injuries, and the like.

Vocational rehabilitation services for young people. Since education is preparation for life, the kind of work young people choose to engage in is an important factor in determining much of life's activities, interests, and accomplishments. Various state vocational rehabilitation services aim to make it possible for young people who are in any way handicapped for gainful employment to have opportunity to choose the kind of work most suited to their abilities and to be adequately trained for it. Services are usually offered to handicapped residents of the state 14 years of age or over. These services include counseling and guidance and, where necessary, arranging for therapeutic treatment. Medical or psychiatric care or corrective surgery are furnished, prosthetic appliances such as limbs, braces, or hearing aids, and vocational training including tuition. During training, needed financial assistance may be provided to meet the costs of maintenance and transportation and necessary books, tools, or other equipment. Assistance is offered in finding suitable jobs. (See Chapter 11.)

Nurse's part in recruitment for schools of nursing. The high school nurse is the person from whom high school girls, and since World War II boys as well, naturally inquire about nursing as a future career.⁽²⁾

Knowing adolescent girls and boys as she does, the nurse can help them understand various aspects of nursing. She has a general idea of which pupils to encourage to enter the profession and which to discourage. She studies carefully any interested pupil and, to increase her opportunities for observing a prospective applicant, the nurse may be able to arrange the pupil's assignment to the health

to recognize and solve their own health problems. She may help the pupil who uses ill health as an excuse to avoid displeasing situations. This is not always done in one conference and the habit may even be so deep-seated that the child needs help from the child guidance personnel. Observations and careful questioning, sometimes over a long period of time, usually reveal the real cause.

Much can be done in individual pupil health counseling regarding care of colds and minor illnesses, including acne. Prevention and care of the more serious communicable diseases such as pneumonia, poliomyelitis, tuberculosis, gonorrhea, and syphilis may be stressed in individual conferences. The pupil should know the reasons for early treatment of disease, of defects, or of injuries and should be assisted in learning the selection of proper treatment facilities.

Study habits, boy and girl relationships, and the like are topics which are often discussed in individual conferences. Today many serious social problems are also discussed in health classes, social science, and English classes as well as in connection with other activities of the school.⁽⁶⁾

Nurse's part in councils and committees. The nurse is an essential member of the school health committee or council. In high school the group usually includes the administrator, school physician, dentist, dental hygiene teacher, health teacher, health counselor or health coordinator, dean or counselor, science teacher, home economics teacher, social studies teacher, art teacher, and other teachers as seem indicated. If there is a psychologist in the community or in the school system his contributions are helpful and he is included.

It is also advisable to have the school custodian a member of the health committee or council. Problems of sanitation and safety and repair of physical equipment may be remedied more easily when the custodian understands the needs through firsthand participation. When he feels his part in the school health program is an important one there is a tendency for him to improve conditions and to be more alert to health problems and accident hazards. Sometimes a member of the parent-teacher association and a representative of

helpful in arranging trips to hospitals and may accompany students on hospital field trips.

The librarian also assists in the recruitment program. She has books and pamphlets on display. She has current information on all new publications and from the various book reviews to which she has access she can recommend books for the different age groups. (See Chapter 10.)

Exhibits, movies, and talks for adolescent and parent groups are another means of developing pupil and parent interest in the nursing profession. Sometimes it is stimulating to have a capable nurse who understands adolescent groups speak to the high school assembly. Or it is advantageous to have a former pupil who is now getting a nursing education return to high school and describe her present activities and experiences.

First aid in the high school. Minor accidents occurring in shops, gymnasiums, playgrounds, laboratories, or kitchens may be cared for under direction of the teacher in charge if these places are supplied with adequate first-aid supplies and approved instructions. Such accidents are reported to the health service.

The nurse is alert to the causes of accidents and stimulates safety education to prevent avoidable accidents. Studies which will help solve some of the accident hazards and prevent further injuries may be made by health education classes.⁽³⁾

It is estimated by those who have studied accident prevention in industry that 85 per cent of all industrial accidents are caused by the human factor—the unsafe act of the human being—and less than 15 per cent can be attributed to unsafe work places or unsafe equipment.⁽⁴⁾

To cut industrial accident rates the school shop stands far up on the list . . . under shop teachers, workers of tomorrow form their future work habits. Whether safe or unsafe habits depend in great measure on attitudes the shop instructor takes toward safety and accident prevention . . . loss, mainly because people are people . . . safety is like morals, a must for the other guy but not for us.⁽⁵⁾

When the nurse is not burdened with a large amount of minor first aid she has more time to give health advice and stimulate pupils

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the study body are asked to join the health committee or council.

In small schools the entire faculty may act as a health committee or council. Cooperation between the personnel of the school, the health committee or council, and any persons or groups in the community who are interested in this area is vital.

Projects for a health committee or council with which a nurse might be especially concerned include:

1. Study school lunch program, school housekeeping, lighting and ventilation, school and community safety, communicable disease control in the school and community, health and recreational conditions in the community, and similar problems.

2. Study ways and means for treatment of defects and making treatment of remediable defects the prerequisite for representing the school in sports, dramatics, musical events, and other sought-after student activities; study relation between presence of untreated defects and pupil failures.

3. Study school library to ascertain amount and quality of health literature. (This would also include ways and means for providing more approved health literature.) The school physician's advice is especially valuable in such a study.

4. Study physical status, attitudes, and practices of pupils.

5. Study health content of all nonhealth courses offered in the school.

6. Study causes of illness absences.

The high school nurse and classroom teaching. Cooperation of the nurse with secondary classroom teachers is discussed in Chapter 16. Participation in courses taught by qualified teachers of home economics, health, guidance or family life is expected of any nurse working in the secondary school to the degree appropriate to the individual circumstances.

There are instances of nurses with special preparation for teaching who do outstanding work in teaching, independently, courses in these fields.⁽⁷⁾ Essentials for success in such situations are that the nurse meet the qualifications set up for such teachers, and that time in her program be allowed for each class, proportionate to the time allowed for each class on the schedule of a full-time teacher. This requires a comparable reduction in the nurse's other assignments.

will be a long time before the full advantages of health facilities and services are available to all rural people. Poor housing is still prevalent, dangerous water supplies are common, and often sanitary facilities are lacking entirely. In 1942 infant mortality was one quarter higher in rural sections than in large cities. Deaths were highest in rural areas from the very diseases that modern science and sanitation are best able to prevent, such as typhoid, diphtheria, and pneumonia.⁽²⁾

Draftees examined in World War I showed rural youths in better condition than urban youth, but draftees examined for service in World War II showed farm youth rejected for physical defects at a rate of 41 per 100 compared with 38 per 100 for the average. Many of these defects could have been prevented by proper care in childhood but cannot now be remedied. It is the children of these men who can be protected from similar ill health or disability.

Nearly one-half million more children live in rural sections of our country than in the urban.⁽³⁾ For these children, major responsibility in health guidance, emotional and physical, rests on parents and teachers to a greater extent than in urban areas. There are fewer physicians, fewer specialized clinics, guidance services, psychologists, and psychiatrists than in urban communities, so the value of what nurses may do to help parents and teachers understand and guide these children is intensified.

Rural nurse and school administrator. Fundamentally the relationship is the same as between any other nurse and school administrator, but because of the travel distances involved and perhaps greater unfamiliarity with nursing the rural nurse may need to be more positive in making clear to him how the nursing service can be used to benefit school health. When she is assigned to school work her first activity is a conference with the county or district superintendent, her next with the principals, if any, and her third (arranged through the superintendent) with the teachers. The nurse is usually introduced at the first teachers' meeting and allowed to explain the services she hopes to give the schools—having previously worked out a program and some simple policies with the school administrators. Through this preliminary explanation opportunities for

*Using the Rural School to Extend Public
Health Nursing and Community Health
Education*

As rural incomes increase, as better roads are built, and as rural people use automobiles, telephones, and electricity more generally, the differences in school nursing for urban and rural pupils will become less.

Establishment of county health units and the building of rural hospitals and health centers bring to rural people the facilities for medical care and sanitation that have long been available only in urban areas. At the same time better schools educate not only the children but the parents to desire the benefits of modern medical science.

School nurses and other public health nurses going into the homes have been a large factor in breaking down the isolation of rural families and the barriers which isolation often raised against their full use of available medical and public health facilities.⁽¹⁾

Refrigeration, freezing, and canning taught by home demonstration agents are improving rural diets, as are also rural grocery and meat routes.

In some areas progress has been spectacular, but in others, it has been only spotty, and in too many there has been none at all. It

riodic reports of her school activities, home and other visits in behalf of school children and the results obtained, unless other arrangements are made.

The nurse in a large school or in schools having a principal usually submits a report of her school activities, home visits, and other concerns to him, with a copy sent through the principal to the superintendent.

Periodic reports including a narrative section may follow a suggested outline or other plan which the superintendent, principal, and nurse may develop. (See Chapter 15.)

Special reports on certain pupils or problems do not necessarily wait for the established report time but are made immediately when indicated, by note, telephone, or in person. When the nurse is new in an area she may utilize these reports as opportunities to become better acquainted with the superintendent and for him to become better acquainted with her. In the beginning there are many subjects on which their points of view may be far apart.

Nursing time needed. Children in rural communities need the same health services as children in towns and cities. Administration of the program is very similar if comparatively large numbers of rural children are brought together in one system, as they are in central schools. Planning for the part of the nurse's work which is done in the school building (testing, inspections, interviews, and the rest) is like that in urban schools.

Because of the longer time required to travel the increased distances involved in making home calls, extra time per capita is usually needed for nursing services in rural schools. Then too the nurse usually allows increased time for a home call, as more advice is sought from her. There are generally more persons under one roof, each with more problems, and the family has less consultant service conveniently available than families in urban areas. More occasions occur in rural areas in which a physician requests the nurse to make a visit for him and report the conditions found.

Certain other circumstances which may require a larger time budget include the following:

In some rural areas a larger than usual proportion of families

future misunderstandings are reduced. All proposed new projects should be discussed with the superintendent as they come up during the year. He may be aware of circumstances, unknown to the nurse, which would affect the readiness of the school or the people to accept proposed changes or innovations. The nurse brings to such conferences her knowledge of program possibilities and the superintendent his knowledge of what has been going on in the schools, what particular attitudes or past experiences might color the attitudes of school personnel and parents.

If the thinking of the nurse and superintendent is too far apart, the sooner the nurse knows it the better. She will have less resistance to overcome if no issue has been raised between the two of them. If he believes that he was the first to think of a plan and anticipates that his prestige may be enhanced by his sponsorship, it is more attractive to him than if it appears as the project of the nurse alone.

When new problems arise for which policies have not been discussed, the nurse confers with the school administrator, often by telephone, as well as with the school physician of the school concerned.

Included in the problems upon which the nurse and the superintendent will be working together are:

- Improvement of physical facilities of the school
- Improvement of sanitary management of facilities
- Procurement of attention of welfare officials to certain cases
- Utilization with parents of exclusion process to secure action
- Development of teacher in-service education programs in health
- Development of material suitable for publicity ⁽⁴⁾
- Development of parent education programs
- Development of community diagnostic and treatment facilities
- Development of community recreation facilities

Reports. Periodically (the interval is established in the original conference) the nurse sends or takes to the district superintendent a summary of work done in his schools.

When the nurse serves several small schools or schools having no principal she should furnish the superintendent directly with pe-

are in the marginal group financially—not on relief but still unable to afford medical care for any but extreme conditions. Medical care is also more expensive for rural families. If local facilities are lacking, as is often the case, more travel expense is required to take a child for treatment, and parents lose more working time to accompany him. In following up defects needing treatment, with families on welfare funds, often more time is required than in similar urban situations. The larger population involved in urban areas has resulted in setting up formal procedures which can be followed with less attention from the nurse, while in a rural community she may be required to make individual arrangements for almost every case.

A smaller proportion of families can be reached by telephone, intensifying problems arising when a child is injured or becomes suddenly ill while in school. Again the distance of home from school increases travel time and expense. Since the school cannot return the ill or injured child to the parent's supervision as readily as in the city, more health supervision is required to take care of emergencies and sudden illness.

The small school. Although the children in small schools often need more service per child than do children in other schools, frequently less service and sometimes no service is provided because of cost, lack of personnel, administrative difficulties involved in arrangements, or other difficulties.⁽⁵⁾

The nurse responsible for a number of small schools may be full time or part time or she may be a public health nurse who includes this work in her generalized public health nursing program. When school nursing service must be spread over various small schools with little or no centralization of administration, nursing problems become more complex. The amount of service needed and provided is governed by location, size, and number of schools, "health consciousness" of the teachers, amount of medical and dental service available in the area, attitude toward health problems of school administrators, trustees, special personnel, and welfare officials. Work outside of the school building as well as within requires special planning and adjustment.⁽⁶⁾

The nurse who accompanies the school physician to schools and

of classroom inspection to point out to the teacher the significance of as many items as possible. Checking instructions for care of emergencies and the first-aid supplies is essential on the first visit. If these are not satisfactory, plans are made for corrections.

The communicable disease chart should be reviewed so that the teacher will be able to use it in an emergency. Equipment for weighing and measuring are inspected by teacher and nurse together to see that it is in proper condition and the teacher understands its use. If such equipment is lacking, plans are made for obtaining it.

As in a home visit, one must not try to crowd too much into a first visit. Plans for vision and hearing testing may be discussed and equipment checked, but actual testing or instructions concerning the processes may need to be deferred to a later time.

An environmental survey of building and grounds is desirable as early in the school year as possible, but time may be lacking on this first visit to make it the educational experience which it should be. The nurse, however, should note and call to the attention of the appropriate person any outstanding hazard which it might be dangerous to ignore. She plans with the teacher for a formal survey later, both teacher and pupils to take part. She leaves survey forms so that the pupils may be collecting some of the preliminary data before her return. These data might include room and window glass measurements on which to base evaluation of adequacy of natural light. When the nurse returns with a light meter she will check further.

The most important thing a nurse hopes to accomplish in her first visit to a school is the development of a feeling of friendliness between herself and teacher and pupils. She may therefore properly delay some of her critical comments and suggestions for changes, should conditions be unusually bad, until a later visit. On at least three matters, however, she can risk no delay. First in importance are her suggestions for obtaining better lighting conditions by instituting measures within the control of teachers and pupils, such as washing windows, adjusting shades, or removing high weeds, shrubs, and tree branches which block the light. Second, the nurse must have the water supply checked if there is any reason for suspecting

child for treatment all arrangements should be verified, and sometimes it is possible to make an appointment for another pupil at the same time. If the nurse (as a last resort only) must take the child for treatment it is desirable that she also plan to take other children needing service on the same trip.

Special plans for parent education should be emphasized. (See Chapter 12.)

As more parents become aware of the needs of their children, and of themselves as well, they realize the lack of facilities and the problem becomes one of community interest. Formation of a local health committee aids in bringing the needs of the situation before the public. Such a committee works out ways and means of bringing more treatment facilities into the community and develops resources for furnishing aid to those who cannot meet the costs of necessary treatment. Of course the formation of a central school district and a county health unit are among the best avenues to community improvement.

Valuable time is saved if the rural nurse knows the location of all homes in her district. A new nurse can obtain this information from the post office, school bus drivers, state police, sheriff's office, or other source. Some nurses learn firsthand by riding the school buses or by taking the school census. A few will keep the information in their heads, while others will want to make a spot map by bus routes or a listing of families with some designation of location. Or directions can be recorded in family folders (see Chapter 14). To be of value any directions about locations must always be up to date. Checking with pupils and teacher for possible changes before making home calls is desirable, especially in the spring months when so many farm families are moving.

Planning the nurse's first visit to a one-room school. This visit as well as all subsequent ones should be used for a double purpose: (1) to stimulate the teacher's health work and (2) to work directly with pupils and parents to get attention for pupils who need treatment.

On the nurse's first visit, unless the teacher is experienced and already competent in health work, a demonstration may be made

Rural nurse and health teaching. Time is well spent by the nurse, in cooperation with the teacher, in planning for health teaching. The most effective contribution the nurse can make to this program is to assist the teacher to understand the health needs of individual pupils, conditions in their homes relative to healthful living, and parental attitudes toward health. She can also assist the teacher to work out plans that will result in treatment of defects, educational adjustments, and a better understanding of health and health practices on the part of pupils and parents.⁽¹⁾

Teacher, principal, and nurse working together can plan to bring about better utilization in health teaching of such environmental factors and school activities as lighting, ventilation, drinking, hand-washing and toilet facilities, school lunches, and first-aid treatments.

The nurse may suggest new and authentic health literature and other teaching aids.⁽²⁾

The nurse should not be scheduled for routine health talks. She can make her most valuable contribution to health teaching when she participates in discussions to which she is specifically invited because of the subject matter to be discussed and her unique training and background.⁽³⁾ Such an occasion might be in preparation for some special clinic—preschool, chest x-ray, toxoid immunization, or vaccination. Or at the time of an epidemic or threatened epidemic, she might take the initiative in recommending such a discussion. (See Chapter 12.)

If there is a high school in the rural area she serves, the nurse gives as much time as she can to cooperation with the health teacher in developing and teaching such units as "Your Personal Inventory," "Health in the Home," "Care of Children," and "Home Care of the Sick." (See Chapter 18.)

Responsibility for health service. The law usually charges the principal or teacher in charge of a school with responsibility for notifying parents of defects found at the time of the health examination. Teacher and nurse share responsibility for follow-up. Sometimes a home visit or a parent conference at school in which both teacher and nurse take part gets better results than either nurse or teacher working alone. The nurse reports to the teacher and

the water in use is unsafe. Children can be required to bring their own drinking water from home as a temporary measure if no school source is known to be safe. Third, some provision may have to be made for handwashing after toilet and before eating. Because it is fall and heating stoves are not in operation fire hazards fortunately do not usually have to be considered on a first visit. Of course if one is found to exist, immediate attention is demanded.

Effective communication between nurse and teacher. When nurse and teacher meet frequently in the natural course of events it is less necessary to establish formal avenues of communication. In the rural situation, the nurse should be careful that each teacher knows exactly where and when she can reach the nurse by telephone. If there is no telephone in the school the nurse also should learn how to reach the teacher.

Few nurses, city or rural, are found using the mails to fullest efficiency. If telephone service is limited, it is especially necessary to do so. If clerical service is furnished the nurse (or if she develops some volunteer or student help for the purpose), certain things can be done to make it easier for the teacher to communicate with her. For example, post cards already stamped and correctly addressed to the nurse are a convenience and timesaver. Or asking the teacher at the conclusion of a school or telephone call to drop her a card with certain information on it by a certain time helps the teacher develop the habit of using this medium of communication.

When visits to individual schools are necessarily curtailed, meeting teachers in groups whenever possible is another substitute way of increasing communication. (See Chapter 16.) The nurse discusses with the superintendent his plans for teachers' meetings during the year and arranges with him for her own participation. She may find it wise to request scheduling of additional meetings for special health purposes.

Up-to-date, complete, and authentic individual health records for each pupil serve as excellent means of communication between nurse and teacher. The more automatic the transfer of information between teacher and nurse becomes, the less chance there is of unintentional omissions.

public health nurse, and not the classroom teacher, has had the preparation and experience to enable her to do this more effectively.

Another difficulty is involved. There are usually emotional implications, and skillful handling is required to avoid development of unpleasant social relations between families. The teacher, because of her lack of experience, is sometimes more apt to share this emotional tension than the nurse and is, therefore, more apt to become involved in personal attitudes. Also, since the teacher may be employed by the very families concerned she may be risking more than the nurse, who, whether working in the schools or as a generalized public health nurse, may be employed by a board that covers a much larger unit.

Coding of causes of illness absenteeism in the register makes the procedure of review of illness records of pupils simpler and more meaningful. The illness absenteeism record may also determine the need for special examinations or rechecks by the family or school physician.

Absenteeism due to work is often an acute problem. According to Mott and Hoemer, "Progress in controlling industrial child labor has no relative counterpart with respect to agricultural child labor, which is for the most part unregulated by either federal or state legislation." (10) Many of these absences may be reported as illness ones.

Lack of home facilities for personal cleanliness has been met by practical health teaching and by use of school shower facilities. Some schools have a bath program which is offered as a privilege (never as a penalty) when needed. In some instances children even use the school laundry for washing their personal clothing.

The nurse working in a number of small rural schools may wish to modify the classroom work sheet. Often she will find it more efficient to make notes of her data by families instead of by individuals. More space will be needed for road directions than for addresses. A notebook used by some nurses contains a marked section for each school which includes pages for each of the following:

principal or superintendent the results of her efforts to secure treatment of defects and any other information about the child and his home environment that should be used for the child's benefit or become a part of his cumulative health record. (See Chapter 14.)

In the rural school the classroom work sheet may be used to very good advantage since teacher and nurse can pool their information about health problems, absences, treatments, and the like. This is an informal record, but at the end of the year, and more often if indicated, all essential information is formally transcribed to pupils' cumulative health records. If this work sheet is kept up to date it is an easy matter for the teacher, with the possible help of the nurse, to make out her annual report. The nurse has a definite responsibility to see that information included in the report is accurate and covers all services rendered. Without her help the report is apt to be an understatement of what has been accomplished for the pupils' health.

Teacher and nurse gain valuable information by reviewing the attendance register. Frequent short absences or any prolonged absences when illness is given as an excuse are usually indicative of the need for a nursing visit to the home.

Rural school teachers must learn particularly to be aware of acute communicable skin conditions and realize that *exclusion without follow-up is useless except as it may protect the classmates of the excluded child*. Sometimes confusion exists as to the responsibility of a public health nurse in follow-up when she is employed by the health department and includes school service in her program. She is an employee of the health department and, since such conditions as scabies, impetigo, ringworm, and pediculosis are not reportable communicable diseases, they may seem not to be her responsibility. But as a public health nurse assigned to school work there are few situations in which her services are more desired and valued. It is true, working in a sparsely populated area, she cannot handle this activity without the teacher's help. Neither can the teacher handle it without the nurse. These nonreportable communicable diseases are basically a home problem. Education of the parents in sanitation, housekeeping, and physical treatment are all involved. The

Heating—satisfactory or guard needed for stove; jacket needed; new equipment needed as heat is insufficient; recently checked by expert

Ventilation—satisfactory or window deflectors needed; mechanical equipment apparently out of order; thermometer should be checked or replaced; position of thermometer should be changed; temperature charts should be kept

Handwashing and toilet facilities—satisfactory or poorly cared for; improperly used; new bowls, basins or toilet seats needed; plumbing repairs needed; undesirable location; insufficient toilet paper, towels, or soap

Drinking water—satisfactory or source questionable; water should be tested; method of dispensing should be changed; pressure in fountain too low; improperly used

Lunchroom and kitchen—satisfactory or additional space needed; stove inadequate, more refrigerator space needed; method of dishwashing unsafe; screens needed

Seating—satisfactory or immovable; unadjustable; not properly adjusted; need repair—rearrangement needed; shiny surface should be refinished dull; greater variation in sizes needed

To save clerical work the nurse will record in her notebook only those items indicating problems. In order to make the survey a more positive experience for teacher and pupils, however, she may suggest that they record completely all items reviewed, both correct and incorrect.

The term "healthful school environment" includes more than sanitation and safety practices. Provision for healthful school living includes not only the provision for a well-planned and well-equipped building but includes also such factors as the length of the school day, attention given to scheduling of classes and recesses, attention to teacher health, and the social and emotional tone of the classroom. In addition to adequate facilities the child must be given an opportunity to use the facilities in a healthful way. Responsibility for maintenance and guidance in the use of these facilities rests upon the entire school staff—administrators, teachers, and the custodian (if the school employs one). Pupils should be made to realize that they have a part in the proper maintenance of the school, its grounds, and its facilities. Above all, they should have an opportunity to observe and practice proper health habits.

1. Visits to school: date, time of arrival and leaving, activities covered, plans for next visit
2. List of pupils probably grouped by families, including: age, height, weight, gain or loss since previous weighing, visual and hearing scores, observations of nurse and teacher, findings and recommendations of physician, follow-up accomplished or planned
3. Notes regarding health education discussions with teachers
4. Notes regarding physical facilities of the school and sanitary matters needing attention
5. Conferences regarding pupils or problems of this school with:
 - Superintendent
 - Family physician
 - School physician
 - Welfare officer
 - Others
6. Other health matters

Survey of building and grounds. On one of her early visits to each school, the nurse makes an environmental survey of building and grounds, with special emphasis on safe and hygienic use of all equipment. Teacher and pupils assist her, in fact may already have collected certain data for her use. (See Chapter 12.)

Items inspected usually include the following:

Location of school building—satisfactorily placed or too near road; trees too dense; too near railroad

Grounds—walks satisfactory, need repair, or insufficient; play space adequate and well kept or insufficient; muddy; littered; waste receptacles lacking; play apparatus satisfactory or insufficient, needs repair, dangerously located

Entrance—satisfactory or screen or storm door needed; glass in door needs protective wire; lighting insufficient

Corridors—obstructions; inadequately lighted; slippery

Stairs—obstructions; slippery; worn treads; inadequately lighted; hand-rails lacking or too high for small children

Lighting, artificial—satisfactory or insufficient; incorrect type fixtures or bulbs; luminaries incorrectly spaced; switches incorrectly arranged; fixtures or globes need cleaning

Lighting, natural—satisfactory or inadequate; poorly placed; cross lighting; windows need washing; shades need repairing or replacement; translucent shades should replace opaque ones; shades should be hung from the middle of window; screens needed

8. Peeples, Doris: "Working Relationships between Public Health Nurses and Extension Services in Rural Areas," *Pub. Health Nursing*, 44:516, (Sept.) 1952.
9. Strang, Ruth: *Concerted Action for and with Rural Youth*. The American Council on Education, Washington, D.C., 1951. 14 pp.
10. Mott, F. D., and Roemer, M. J.: *Rural Health and Medical Care*. McGraw-Hill Book Co., New York, 1948, p. 26. 608 pp.

The law in some states requires the school physician to report insanitary and hazardous conditions to the administrator. In addition, he may delegate routine inspections to the nurse and other school personnel. The nurse's responsibility in this phase of school health service goes beyond the mere checking of the survey form. She must recognize undesirable conditions and practices as they occur and must take steps to obtain their correction. Most health habits are learned by doing. If facilities that should contribute to health are lacking or are faulty, little if any learning will result.

Environmental surveys have little value unless the violations and shortcomings are brought to the attention of the principal or superintendent for his presentation to the trustees for action. Often the teacher or janitor can replace unhygienic equipment and correct undesirable practices. In other instances, action by the trustees is necessary. If anything further is needed, the problem should be referred in writing to the superintendent.

Provision of a healthful school environment and facilities is fundamental. Getting the pupils to respect these facilities and to use them properly is a good test of effective health teaching.

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which may accompany it under other circumstances. If it is delayed too long or if it occurs in connection with some family cataclysm, he will find it much more difficult.

Although group experiences are being offered increasingly to children as part of their school life and in many out-of-school activities, camping is still unique in the extent and breadth of its possibilities along this line.

The nurse who has observed the effects of a good camping experience upon children she knows well has been pleasantly impressed with their increased realization of the relationship between happy comfortable living and good health and between the practice of vital health rules and good health.

Usually there is also a healthy growth of self-confidence as they have learned how to live comfortably and safely under new conditions. They are happily conscious of greater skill and judgment in meeting new situations. Of course these outcomes result only if the usual hazards which might be encountered have been recognized and the campers adequately prepared to meet them. Also, adequate adult counsel must have been available on the spot to give the children guidance when unusual hazards have occurred so their developing self-confidence was not destroyed by fear or failure.

Choice of a camp. As an advisor to parents the nurse is expected to be familiar not only with camping advantages in general but with sources of information about the facilities suitable for a particular child. He may have special needs, physical or emotional, or special capacities, as in music, art, or the natural sciences. Or a child may have developed such a one-sided life from an extreme interest along a too narrow line that, when he goes to camp, the emphasis should be on his all-around development.

The nurse may help the parent get in mind the questions that should be answered in order to make a decision between several possible camps. Some are questions which parents must answer for themselves; others the camp management will answer for them. Parents wish to know: what do they want the child to get from this experience? Some camps emphasize group loyalty,

The Nurse and Camping for School Age Children

The nurse is concerned with several aspects of camping programs. For improvement of the physical, social, or emotional health of a certain child whose parents she is advising, she may wish to suggest utilization of a camping experience. Another aspect may be her participation as a member of the school or health department staff in a camping program for school age children carried on by the organization which employs her. Another possibility is employment during her vacation period by another organization engaged in a camping project for school age children.

Advantages of camping. The nurse appreciates the value of camping experience for any child; he does not have to come with a "problem" in order to profit from camping. Among these values are the fun he will have, opportunities for recreation different from those at home or when taking a vacation with his family, an opportunity for him to take a definite step under as pleasant conditions as possible in the "psychological weaning" from his dependence on his parents. In such an instance his absence from home has been planned for in advance; he has had a part in the decision that he is to go; it is for a specified period of time and the time is to be filled with interesting activities. All of these factors help to make the separation lose many of the most painful elements

nursing service.) Is the terrain such that the child can traverse it safely? Can the camp meet the dietary needs of the child? Are the toilet facilities such that he can use them comfortably?

A second group of questions must be answered by the camp administration: Does it understand the conditions under which the child must live? His limitations? The adjustment of the camp program that will be necessary for him? Most important of all may be this question: What is the philosophy of camp administration in regard to individual differences of all children? Is it such that each camper has a program of his own? That every child is not expected to follow the same program at the same moment and for the same length of time? For when each child has a tailor-made plan for his day, there will be no embarrassment in the special program required for the handicapped child.

In spite of his handicap will the child be allowed to live as a responsible member of a group, of whom certain services for the group are required? Will he have a chance to make new friends and learn new skills? Will the necessary effort be made to discover special contributions he can make to group life and activities? Can the counselors be given enough information about and understanding of the child so they will be able to help him adjust to the situations occurring throughout the day and so they will be able to meet any emergencies that may arise? Can all this be done and the counselors still treat him as they do the other campers?

To answer these questions affirmatively there would have to be a high ratio of counselors to campers and a health staff personnel with ability to carry on an effective staff education program as a continuing activity throughout the camping period. Planned opportunities for such a staff education program would have to be arranged.

The parents of a handicapped child who is to be accepted at a nonsegregated camp would owe the camp management certain things. A first essential is an accurate diagnosis of the child's condition. He should have been under expert and intensive health supervision for a sufficient period of time so that his capacities and limitations have been definitely established. A frank and complete

and by awarding groups rather than individuals, they stress group cooperation rather than individual rivalry. If the parents' particular ambition for the child at the time is for him to develop superior skill in a particular sport, the choice might well be a camp where individual competition is emphasized.

How radical a step toward freedom from the family is desired at this time? The step is less radical in proportion to the camp's nearness to the child's home, in proportion to the number of prospective campers he already knows, and to a higher ratio of counselors to campers.

What is the philosophy of the camp management in education and discipline, in racial, religious, and social discrimination? How are homesickness, accidents, and illnesses handled? What are the policies on parents' visiting? Do the parents approve these philosophies and policies?

Is the child ready both physically and emotionally for the experience? This is especially important when the child is one with special problems. And for such a child the parent must be kept from expecting too much from one camp session. Long-term difficulties cannot be eradicated in a few weeks. But much can be accomplished if the camp is well chosen and if parents, teachers, and others concerned with the child prepare him for the change and give the camp personnel a maximum of help in understanding him and his special requirements.

If the child is unable to take care of his own daily needs or if he has not learned his own limitations, the camp selected must be a segregated one designed specifically for children with his handicap.

There are certain advantages if a handicapped child can participate in normal camp life rather than in a segregated one; if there seems a possibility the child might manage this, the nurse encourages the parents to consider it. In this event, additional questions which must be answered include: Does the child's physician understand what the conditions at the camp will be and does he recommend that the child be sent? Does he consider the medical and nursing services adequate? (For cardiac, diabetic, or epileptic children this would mean a resident physician as well as complete

preparation of parents is also required. As the nurse has opportunity, she discusses with the parents of pupils scheduled to go to camp in the next year or two, the general benefits for all pupils, and, in certain instances, special benefits that particular pupils may hope to get from it.

The nurse's part in planning. Her judgment and experience will be of value in planning hygienic arrangements for daily living. If sleeping bags are to be used, she will insist upon linings which can be cleaned, disinfected, and deloused. If cots are to be used, she will advise as to desirable types, choice of location for them, amount of bedding to be required, and as with the bags, arrangements for cleanliness. She will be concerned with the convenience of the arrangements for handwashing before eating and after toilet. Swimming no matter how many times a day will not take care of this need, and if facilities are inconvenient they are not apt to be used.

She is careful not to set herself up as an authority on sewage and garbage disposal facilities, or on pure water supply, or on proper drainage of the grounds. She does know well that expert authoritative advice must be obtained on these matters. She secures and has for easy reference pertinent publications on the subject from her state health department, from the American Public Health Association,⁽⁴⁾ and from the American Camping Association.⁽⁵⁾ From the National League for Nursing she obtains information about camp nursing.⁽⁶⁾

She helps to plan infirmary facilities, including provision for isolation in quiet surroundings apart from general living quarters. While the general recommendation is a minimum of an infirmary bed to 15 campers, the number of beds needed decreases in proportion to the nearness of the camp to the homes of the pupils. Waterproof and fire-resistant materials are used whenever possible in equipping the infirmary and also for the health cabin or lodge.

One of the most important functions of the nurse in preparing for camping is arrangement for precamping examinations of all the staff and prospective campers. Examination of stool specimens of all food handlers is recommended, including those pupils who

statement of his condition and exact recommendations concerning the types of activities desirable for him as well as of the limitations required is the due of the camp management.

The nurse and the school camp. School camping is new in one sense—that is, as a public school function. However a private boys' school, the Gunnery School for Boys in Washington, Connecticut, moved its student body and faculty into camp quarters each summer from 1861 to 1879 and engaged in many of the activities of current school camps.

Public elementary and secondary schools are now experimenting with various plans for utilizing camping experience as part of their regular educational programs. Sometimes the school owns the camp facilities; again facilities of park commissions and of state conservation departments are utilized by the schools.

From the sixth grades of San Diego (California) City and County schools, about 80 pupils at a time are sent to Camp Cuyamaca for a one-week period.⁽¹⁾ The camp staff is made up of a director (who is a school principal), 10 counselors, a nurse, chef, first cook and kitchen helper, and two maintenance men. In 1948 Michigan began a series of experimental high school camps.⁽²⁾ Life Camps, Incorporated, have conducted experiments with New York City children.⁽³⁾ Boards of education of village and even of rural schools in upstate New York have developed camping programs as part of their regular curricula.

The nurse of the school from which the pupils are going to camp has an important responsibility even if she is not the nurse who is to accompany them. The Committee on Camps and Camping of the Maternal and Child Health Section of the American Public Health Association has recommended that unless there is a physician in residence (or a medical student who has completed two years of his medical course) a nurse should be employed when the total number of persons including campers, employees, and administrators is greater than 75.⁽⁴⁾

The nurse of the school from which the pupils are going has an important role to play in the preliminary planning and in the preparation of the pupils for the experience. In some instances

of style facilitates cleaning and allows for freedom of action. Shoes are fitted large enough to allow for wearing extra pairs of socks and for swelling which develops on long hikes. Ventilation of shoes is important. Corrugated composition soles are the least slippery of the waterproof styles.

Preparation of instructions for the pupils as to the care and cleaning of personal articles while in camp is in the nurse's area also. If there is a home economics teacher, she also assists in these plans.

The nurse participates in mapping out the daily activity schedule to ensure a program of balanced living for each pupil and necessary adjustments for children with special needs; to ensure a gradual transition from a more sedentary schedule to a more strenuous one; to arrange for enough flexibility in all programs so the child who must be restricted will not stand out as "different."

The nurse at camp. Here the nurse will find that some of her best opportunities to serve the interests of the children will come in working through the counselors, just as in school she works through the teachers. To function effectively on this plane, however, she finds she needs to learn about the philosophy and techniques of camping. An "R.N." may be sufficient preparation for a camp nurse who is not going to venture out of her infirmary tent and who there confines herself to bedside nursing after a sick child has been turned over to her with the physician's orders at hand. It does not suffice, however, if she wants to take advantage of the 24-hour living plan to consider the whole child and all of his health—physical, mental, social, and emotional. It does not suffice if she wishes to integrate the health activities for which she is responsible around the general problems inherent in out-of-door group living. If the nurse is unprepared to do this, even her infirmary work suffers as the infirmary period becomes a time when the child is out of camp life and might just as well be at home in his own bed or in a city hospital bed.

Suitability for the work. Unless the nurse really likes working with children and enjoys sports and outdoor living, she should not

may be going to participate in food preparation or dishwashing.

Such immunizations as are indicated by the location of the camp and the age of the individual are insisted upon for staff members as well as for pupils.

There is an advantage in having the examinations of the pupils made long enough before the camp period to allow time for the correction of remediable conditions before leaving, but not so far ahead that too many new conditions might develop. A last-minute inspection just as the children are leaving school for the train or bus is desirable. These are made by the nurse if a physician is not available.

If the services of a nutritionist, home economics teacher, or dietitian cannot be secured to supervise meal planning, purchase of food supplies, and sanitary arrangements for food preparation and dishwashing, the nurse may have to concern herself with these matters also.

Camp director, school physician, and nurse participate in selecting first-aid equipment and supplies and in planning special instruction in first-aid procedures for both counselors and pupils. This instruction is sometimes given before but at other times seems preferable at the beginning of the camping period. In addition to the equipment for the main first-aid station in the camp, small special kits are prepared for each cabin or tent, and to take on out-of-camp trips.

The list of clothes, toilet articles, and other individual equipment to be asked of or provided for each camper will profit from review by the nurse and the suggestions she may give. While the amount of personal baggage may be kept down by choice of garments which provide for multiple uses, this does not apply to socks and shirts. A larger number of light weight, rather than heavy, allows for wearing two or three at a time for extra warmth but with greater comfort and less extra baggage than when heavy ones are used. Strong but lightweight and soft, waterproofed materials may at one time provide protection against rain and cold and at another protection against sunburn, insects, briars, and brush. Simplicity

and weaknesses and a program arranged to meet his particular needs.

Another valuable improvement resulted from the study pointing to dangers from overorganization of the program—the crowding of too many activities into the schedule, and the too strenuous and too continuous stimulation of the children, hour after hour. The rest hour after lunch is now well established. There is still a struggle in some camps, and with some individuals in all camps, to strike the right balance between active and inactive pursuits. Too much inactivity is undesirable too, as there must be enough physical activity to develop the child and to make him tired enough to sleep well at night.

Homesickness—a special health problem at camp. The best work of a nurse on this problem is done before the children leave for camp. As a school nurse she has a nice opportunity to do effective preventive work beforehand to reduce the occurrence and intensity of homesickness.

For the child who has never been away from home, this break is second in severity only to the shock of starting to school. The parents' reaction to the break may be the basis of the child's problem or it may be an added one. The school's camping program can well include an "indoctrination course for parents" in which the nurse will participate. If the parent is taught how to help his child avoid a "fatal" case of homesickness (for certainly failing to stay the planned period will make it still more difficult for the child to make a future adjustment away from home) the parent may also learn how to reduce his own attack of "childsickness."

The parent is warned against expecting too much from the camp experience in the way of remaking the child, and especially against allowing the child to think he is going to camp because his parents are dissatisfied with him. Both parents and child need to look upon it as an unusually happy opportunity for normal growth and development. The child should be encouraged to ask questions about anything which worries him in contemplating the camp. If the parent does not know a reassuring answer, the matter may be discussed with teacher or nurse. If he asks for instance, "What will

dren. If the parents leave when a child has some responsibility to meet so that he does not feel empty after the departure, another hazard is avoided.

Sometimes the nurse may be more successful than the counselor in discovering contributing factors to the child's unhappiness. It may be childlike letters from the parent or emotional telephone calls; perhaps he is not accustomed to undressing before others; the quietness of the woods or the small animal noises may frighten him. Temporary concessions to tide him over his adjustment are well worth while. These might be letting him change the location of his cot so he will have more privacy; putting him further from the entrance or nearer the counselor; or perhaps allowing him to sleep in the "health tent" or infirmary for a night or two; or putting him with a well-adjusted camper if there is one whom he knew before or whom he especially likes—certainly removing him from the vicinity of any other homesick child. The nurse will find no other condition as contagious as this last one.

Complications resulting from the parent's rushing to camp may be avoided. The parent may be warned to understand beforehand that the child's letters may sound much more homesick than he really is, since his mind is centered on home while he is writing. As soon as he finishes his letter and is busy in an activity he may be all right. It is a good precaution to instruct the parent to telephone the nurse or the counselor following receipt of a disturbing letter from the child for an up-to-the-minute report of the child's condition before making contact with the child or taking any action.

The child who feels secure in his place in his family and accepted in his camp group is best able to live through his homesickness.

Preservation of health and safety. To have the child come out of his camp period with glowing physical health and serene mental health means there has been a vigorous physical life and plenty of excitement, with sufficient but not too much attention to safeguards and with careful but not too obvious planning for a proper balance in time scheduled for eating, sleeping, resting, working, and playing. If any camp is to be a success, parents must feel an assurance that their children will be well, happy, and protected.

I do if I get sick?" instead of a casual "Ob, you won't get sick," a statement that he will get the same sort of care he would get at home, that the doctor will come to see what he needs, and the nurse will be there to take care of him will not only be more truthful but more comforting.

If the child is not already accustomed to spending nights away from home, it may be suggested that he be given such opportunities before the camping period arrives. A visit to someone already close to the child, or if this is not possible, two visits to a friend's home, one accompanied by a member of his family preceding a visit by himself alone, may be desirable.

Discussion of the letters he will write and receive, assurance that he will still be an important part of the family even though he is some place else, and the parent's expectation that he is going to have a good time, will all be helpful.

Attacks of homesickness are most apt to occur at mealtime and in the evening and are most acute the third or fourth day of camp. If special chores and responsibilities to make him feel useful and activities to take his mind off himself are not sufficient, it may help to let him talk it out with his counselor or the nurse.

Letting him know that practically everyone feels homesick under such circumstances and getting him interested in trying to remember if he felt better or worse yesterday may help. Making a bargain with him that he may go home after a certain number of days if he still wants to may carry him through.

Among the advantages of a school camp as far as homesickness is concerned is the fact that he is with familiar people. Also the hazard of an attack of homesickness when his parents, who have brought him to camp, are about to leave is avoided when the child comes with a group of his associates and leaves his parent at home just as he does when he is going to school for one day.

Parents' visits to camp may cause an attack of homesickness. The number of visits should be kept to a minimum and they should be short. Instead of a private family reunion, it is preferable to make the visit an occasion for entertaining the child's tentmates and counselor, or a camp-wide celebration for all parents and chil-

to discover those who are losing weight, and if it is found that loss of weight is not desirable, arrangements can be made so that his schedule is less strenuous. It is no longer considered that a camp's success can be measured in terms of pounds gained by the campers.

Failure to sleep well is another occasion for special observation.

At a precamp conference, the physician and nurse explain and, when indicated, demonstrate the standing orders prepared for general staff use and for trips. The supplies to be available in each living unit are likewise reviewed, and a definite understanding reached between health service staff and counselors as to the line between conditions indicating counselor's treatment and those demanding referral to the health service. A plan is decided upon to provide assurance that all campers (and employees) referred to the health service actually get there. With younger children this may be by having someone accompany them. Usually, however, a method less obvious is more desirable. For instance, each counselor may place in the nurse's mailbox at a certain time each day a list of individuals he has referred during the preceding 24 hours. One or two check-ups of failure to follow such instructions, followed by appropriate discipline, are usually effective in establishing a pattern of good cooperation in reporting as directed.

It is likewise good procedure for the nurse to furnish the counselor with a list of the campers whom she needs to see again and the time she would like to have them come. When reporting back to a counselor on a referral that has been made by her, use of the mailbox is preferable to sending a note by the child. If this involves too much delay, and it is impossible for the nurse to see the counselor, a note by the child is better than a verbal message through him.

Definite designations are made of the individuals who are to be responsible when the physician and nurse are not available. A simple method is established for recording a few pertinent facts regarding any first-aid treatment given by anyone, so that they may be reviewed by the physician or nurse and followed up if indicated. All medicines or first-aid supplies brought by campers

If parents do not have complete confidence in the camp management and direction, a school camp will simply cease to function as there is no possibility of appeal to new clientele each season.

Continuous health supervision. A definite over-all plan for this will have been made by the camp director with expert help. Before each camp period begins physician, nurse, and director may have a preliminary conference, followed by a consideration of all problems involved with all counselors present. Here will be outlined the general plan for allocation of responsibilities. Schedules will be made for a conference for each counselor with physician or nurse to review the health examination records, parents' questionnaires, and recommendations for each camper in his group. Recommendations may relate to restriction of activities, special foods to be included or omitted, extra rest periods, or certain health habits which need special emphasis. Although informed about any tendencies toward colds, allergies, sleepwalking, bed-wetting, and the like, the counselor is warned to make no mention to the child of his knowledge of these difficulties, unless the occasion requires it for the child's safety. It is of value to the child to feel that he is starting with a clean slate.

Counselors are encouraged to develop their ability to check up informally on skin conditions, cuts, bruises and scratches, or signs of fever, as they move about the tent or cabin while the children are washing, dressing, and doing their morning chores. More valuable than intensive inspection when the child is at his best after his night's rest is being alert all through the day to such signs of fatigue as excitable talkativeness, pallor, listlessness, or irritability, or any indication of a possible approaching illness, such as coughing, headaches, sore throat, any new swellings, pimples, or indications of sunburn or skin poisoning. Redness of the eyes or irritations of the lids are also important.

There will always be some children about whom the counselor should make a daily report to the health service. Included would be those who have recently recovered from an illness, been exposed to a communicable disease, or are being intensively observed for signs of strain. Weekly weighing is considered a good idea in order

Preventive measures are many and effective. Medical knowledge of persons with actual food allergies, and adequate arrangements for careful selection of their foods, is a must. Employment of a cook who really knows how to cook, both safely and appetizingly, is the best preventive of a large block of troubles.

Earmarking a generous amount of time for eating and establishing a firm policy of no early excuses for any reason whatsoever, developing a pleasant social atmosphere in the dining room, serving small first servings with as many seconds and more as desired (provided all of the first serving has been eaten), mean that management has done all it can to ensure a well-balanced diet for all and conditions that favor good digestion.

For those who wish to gain or lose weight, a special table may be a help, provided the groups are also given sufficient instruction to understand as well as to consume the special diet.

Since the most perfect three meals a day prepared and eaten may be of no avail if bad between-meal practices are followed, and since most children seem to demand between-meal feeding, a snack bar under camp supervision may be indicated. A system of certain foods available in unlimited amounts and without charge and others charged for, but definitely limited, has worked well.

Advice to parents concerning the types of foods acceptable and regarding all food presents as a treat for the child's group rather than just for him can result in "food from home" which can be well fitted into the day's dietary plan.

Lunches to be taken on hikes need to be as carefully or even more carefully chosen than are regular meals, as the hikers are under more strain. Observance of a child's digestive weakness or allergy is most essential. Even the youngest children must understand about making water safe before drinking it, and about not eating unknown berries or fruits, since a counselor cannot watch all of them at the same time.

Rest and sleep. Regular hours for the night's sleep and a rest hour after lunch of a definite required length are now well-established plans in all camps. A nurse sensitive to the needs of individuals or the group as a whole may find it wise to allow an increase

or staff should be reviewed by the physician, and in the case of the children certainly, and sometimes of the staff as well, they should be turned over to the health staff until needed or returned at the close of camp.

Sunburn and poisoning from vegetation. Proper instruction and careful supervision prevent most trouble with these two afflictions which have the power to ruin a camp experience for a child. Protective lotions should be available in each living unit, and their use and the length of time a child is exposed to the sun should accord with recommendations of the health service. Proper hats, clothing, and use of sun glasses are also matters for supervision by an appropriate counselor. Protection against poisoning from ivy, oak, or sumac is best secured by making the eradication of all such plants within certain areas a first order of camp business. Just as certain swimming privileges have to wait until the camper passes definite tests to ensure his safety, so campers may be limited to "safe areas" until they have learned to recognize these plants when they are encountered.

Helping campers to realize how much pain and incapacity they may save themselves by getting early treatment, if they have been so unfortunate as to become infected, will reduce the amount of damage resulting.

Food difficulties. Bringing together at a common table individuals with widely differing food habits can be expected to result in some difficulties even if actual allergies are completely eliminated. More roughage than usual may irritate one intestine, while more refined foods than another is accustomed to may cause a troublesome constipation. Children who are accustomed to routine use of cathartics are upset when they are withdrawn. Eating berries and fruits found on hikes, candy and soft drinks bought at refreshment stands, unfortunately also happen too frequently. The result is upsets.

Inappropriate "treats" sent by parents may offer another problem. Gulping large quantities of cold fluids, when hot or exhausted, may cause serious conditions, as also may be the use of unsafe water on trips.

Responsibility of the school nurse to the nonschool camp, free or part-pay. School age children are sent to many types of camps in addition to those provided by the school. Welfare agencies and settlement houses were pioneers in the camping movement. School children were included with, and separately from, mothers and babies. Associations for the prevention of tuberculosis sponsored many children's camps as primary projects and later, as the numerous "preventoria" which had been developed for care of "pretubercular" children were discontinued as such, some of them were utilized as summer camps. Sectarian groups and other religious nonsectarian organizations such as the Salvation Army and Bible groups were responsible for a large number of camps. Labor unions sponsor them.

"Fresh air farms," "fresh air camps," "vacation camps," and "vacation farms" are some of the names used. Newspapers have been successful in sponsoring camps and also in the parallel project of arranging visits of city children to hospitable families in rural and small village communities.

The nurse was the leader, and continues to have an important part in choosing candidates for the large group of camps developed primarily for children whose families are financially unable to pay for all or perhaps for any of a child's camping expense. Not only selection of campers, but even their preparation for going to the camp may be assumed by the school. This may include the preliminary examination, its follow-up, and a final inspection immediately before leaving for camp to ensure absence of communicable skin or scalp diseases.

Where the school is involved there is a better opportunity than in connection with some other types of camps for the nurse to stimulate an increased two-way transfer of information between the school health service and camp personnel. In some states the law may require that a request for such transfer from the school to a cooperating agency be made by the parent. Information of value to both services includes the pupil's history, his health needs with emphasis on his emotional and social health, and most important of all the progress he has made. Exchange of this information not

in the amount. She will also want to be alert to problems resulting from lack of sufficient rest for certain counselors or other employees.

The usual standards for the night's rest are:

Ages 6, 7, and 8	11 hours
Ages 9, 10, and 11	10½ hours
Ages 12, 13, and 14	10 hours
Ages 15, 16, and 17	9 hours
Adults	8 hours

While children sleep better if healthfully fatigued, the nurse may be more conscious than other counselors of the possibility of excessive fatigue resulting in poor sleep.

The nurse should assure herself that the prebedtime activities are not of too stimulating a nature either mentally or physically.

Visitor's day. This is a feature of camp life concerning which few general statements can be made as the policies and practices vary greatly. On one subject there is general agreement—that such days are most disturbing to the smooth-running routine of camp life. In spite of this disadvantage, some camp managements feel the visitor's day has values.

Some camps, especially those giving short-term camping experiences, have discontinued visitor's day entirely, or have minimized the disrupting effect by limiting visitors to the last day of the camping period.

If education of parents to appreciate the values of camping is one of the objectives of the camp (and in the case of school camps it is, of course), visits of the parents are encouraged. They must, however, be carefully planned and definitely limited.

While parents' visits are considered a real hazard in relation to the child subject to homesickness, there are a few children who tend to express emotional upsets in stomach-aches, colds or headaches, for whom a periodical and definitely anticipated visit from the parents serves as a preventive.

Records. The need for and value of records as established in the nurses' school health service are applicable and even intensified in the camp situation.

for their vacations, but in other instances, the vacation period may also be the best opportunity for a closeness and unity of activities not possible during the father's regular working months.

When such camping is planned, the nurse may review with the parents certain possibilities for the child. Living with the child in camp, the parents or camp nurse have a fine chance to observe and unobtrusively seek to eliminate certain shortcomings. When the environment is changed, it is often easier to eliminate features associated with undesirable traits of the child.

The nurse as a staff member of a nonschool camp—her contract. Before accepting such a position, the nurse should familiarize herself with the publications mentioned in the previous section and with any other camp material available. While many of the large organizations sponsoring camp programs have set up excellent standards for the physical equipment of the infirmary, for medical service, and for personnel policies for the nurse, such standards are not too well established among smaller or independent camps. If the nurse's experience is to give her as many satisfactions and as few frustrations as possible, some preliminary attention to these items is wise.

The following list includes some of the points on which the nurse should attain assurance before signing her contract: Unless there is a resident physician she will want to know that the camp management has a definite agreement with a physician licensed to practice in the state to be on call at all times and that the nurse's judgment shall be accepted as to the necessity for such a call. That there shall always be at camp someone in addition to the nurse who has had special training in first aid and that all such persons shall follow the camp's established standing orders for first-aid service in the physician's absence. That there are satisfactory arrangements for emergency telephone and transportation service. That the nurse shall have authority to inspect and to schedule for inspection by the physician any staff member, employee, or camper. That adequate infirmary provisions have been made, and that there are adequate supplies; satisfactory provision for feeding infirmary patients, and for infirmary laundry. That there are arrangements for supple-

only increases the effectiveness of the health supervision the child receives, but enables both staffs to understand him better.

Organization camps. Character-building organizations such as Boy and Girl Scouts, YWCA, YMCA, YWHA, and YMHA, Camp-fire girls, 4-H groups, and some of the organizations already mentioned, sponsor camps. With all of these there is a value in group association and exchange of information. Between the personnel in such camp, and school personnel, however, the relationship is not usually as close as that in the camps described above. The same advantages result if the relationship becomes closer.

Private camps. Between the so-called private camps and the school health service, the relationship is often developed to a still less degree. The nurse's only service may be to advise parents concerning a choice of camp for the child. The nurse may keep in mind the possible advantage for a certain child of a camp at a considerable distance to which he travels by himself. There may be a longer camp term available; the choice may be between mountains and seashore, a cold or warm climate; there may be a greater choice of development of a special skill.

For children with special disabilities, there are available hay fever camps, camps for cardiacs, epileptics, cerebral palsy, diabetics, or for special instruction such as lip reading or speech correction. If the expense proves too great for a particular child, the nurse may be able to obtain funds from the organization interested in the particular handicap.

In these instances, as in the placement of a child in a special school, careful consideration must be given to weighing the disadvantages against those in placing the child in a camp with "normal" children.

Organized camps vs. family camping. There may be certain children for whom the nurse suggests to the parent the value to the child of boarding on a farm, or perhaps of camping with the whole family. The development of public camps makes it possible as never before for families to camp. Municipalities, states, the U.S. Forest Service, and the National Park Service all offer facilities for families at little or no cost. Some families need to be separated

College Nursing

Development of college nursing. College nursing originated from two different sources. In residential colleges, infirmary services began early to utilize a nurse's services both for bedside care and carrying the advisory service in the absence of the college physician. In many teachers' colleges when the need for some sort of health education and health supervision was first felt one person was sought as a staff member from whom something of both could be obtained. Often the first person to be so employed was a nurse—by choice a nurse who had been a teacher before she took up nursing.

During the earliest period in the development of health programs in general colleges, during the "physical education era" when examinations were given to determine the students' ability to stand the activities of the "gymnasium," nurses had not yet appeared on the American scene as professionally trained workers. Almost as soon as they did appear they began to be utilized in infirmaries.

The picture in 1913. In the discussion of college health programs at the Fourth International Congress on School Hygiene in 1913,⁽¹⁾ the nurse appears as a casually accepted member of the staff. There are references to the "resident nurse" at the Kansas State Normal College. At Princeton the infirmary is "in charge of an infirmarian who is assisted by the necessary nursing and hospital force." Amherst provides an infirmary of 13 beds in charge "of a

mentary nursing personnel in case of an epidemic, and for hospitalization when indicated. That the nurse shall have a voice in determining camp policies relative to nursing matters. That it is understood, if the camp is a small one and the nurse has time for duties in addition to nursing activities, that her nursing responsibilities shall get first priority. That there is provision for "relief for the nurse" certain hours each day and for an entire day or longer at periodic intervals.

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In the nineteen thirties. The great variety of responsibilities expected of a nurse working in the college health program in this period is indicated in various articles appearing in *Public Health Nursing*. In 1932, the nurse at State Teachers' College at Chico, California, is shown functioning as instructor in hygiene and health education, as school nurse for the elementary practice school, as assistant dean of women, as well as in the nursing which was supposed to be her main function.⁽³⁾

In contrast to this type of program is that of the nurse writing in 1933 of the work she has been doing since 1928, as a college nurse at Wooster, Ohio, where with an enrollment of 1800 students she is one of a staff consisting of a full-time medical director, two nurses, a secretary, a housekeeper, a helper, and a janitor. Here the hygiene courses are taught by the physical education teachers, but this nurse gave orientation lectures to women students. We think of college concern for maladjustment in students as something yet to be developed in many colleges, but this nurse comments that mental and maladjustment cases are referred from the dean's office and because of the "sympathetic and intelligent service of our medical director, many of these cases have been definitely helped and are living normal healthy lives as a result."

In surveys of the extent of student health work in colleges and universities, the growing use of the nurse is seen, but little of the activities or numbers of nurses.

A study made by Moorhouse,⁽⁴⁾ in 1935, includes the following data on the ratio of nurses to students in the eleven selected colleges to which she made visits to observe the nursing programs:

2000 students	10 nurses
1300	1
1200	8
1000	3
750	2
600	2
510	1 full time and 2 part time
475	3
350	2
250	2
160	1

matron who is a trained nurse." Teachers College, Columbia, has a "resident trained nurse . . . who acts as an office nurse." At the University of California there is a "superintendent and six nurses, extra nurses being called in when the work requires it."

After World War I. Following the war, many teachers' colleges and normal schools in the United States and Canada added nurses to their staffs. At the World Federation of Education Association meeting in Toronto, a description was given which was typical of many of the programs established in 1918-1920: ⁽²⁾

In 1918 a nurse, a member of the school hygiene staff, who had been previous to her nurse's training a successful teacher and had also considerable experience as a rural school nurse, was appointed to the staff of each provincial normal school [in Canada], in charge of the work in health education. This was a pioneer effort as far as Canada is concerned. . . . The course is intended primarily to teach the most effective methods to be used in health instruction and to equip the young teacher for the many problems which will confront her. But first she must realize in herself the need for such teaching. To this end every effort is directed toward health supervision in normal school and toward rousing the interest of the student in her own health.

Health supervision is maintained both during and following the regular hours of the normal school day. All cases of illness are reported to the nurse and many home calls are made, a feature of the work thoroughly appreciated by the student. . . . Our normal schools have no dormitories so that our very young students . . . are living in boarding houses. . . . We have attempted something in the nature of supervision of such houses . . . serum protection against communicable diseases is provided. . . . The first aid treatment of accidents is another situation occurring frequently and serving as a demonstration of the value, for the teacher, of such knowledge. Cases of communicable disease develop at times among the students and the control of contacts through the office of the nurse is an object lesson of a teacher's responsibility on such cases. Thus throughout the entire year, as each new situation is utilized as a teaching point, the student is consciously or unconsciously acquiring a new health ideal. . . . The actual teaching in the school is given the position of supreme importance throughout the term. . . . Special school activities are outlined and demonstrated. . . . In the practice school the methods discussed are demonstrated with real children and health lessons take their place with other subjects and are given equal attention by the critic teacher, who is frequently the normal school nurse.

health education; 34 had from one to three years of college work; 15 a certificate in public health nursing; and 9 had had public health experience.

In 1949 a second survey sponsored by the same group was reported by Raidie Poole.⁽⁷⁾ Every third institution listed in a United States Office of Education report on "The 1947 Fall Enrollment in Institutions of Higher Education" was sent a questionnaire. From the returns, data were summarized regarding the preparation and employment conditions of 283 college nurses. Of these, 45 per cent had four to eight years of preparation beyond high school. The more highly qualified nurses were found more often in colleges with enrollments under 2000 than in the larger institutions.

In the group studied, 58 nurses had had teaching experience before taking their present positions; 93 had had experience in school or public health nursing or in another college; 58 had had supervisory or administrative experience.

Some 12 per cent of the nurses worked in the infirmary only; 22 per cent in the clinic only; and 58 per cent in both clinic and infirmary.

Of the 42 nurses (15 per cent of the total number) who taught college classes, 36 were in colleges with less than 2000 enrollment.

Of the 283 nurses, 74 carried two or more "administrative" functions, such as directing the infirmary or presiding over the health committee; two thirds of these were in the smaller colleges.

Twenty were "nurse superintendents" or "directors of college infirmaries"; 16 were "nurse directors of health services," and 2 were "directors of college health programs" (both in colleges with less than 1000 students).

College administrators reported that they had employed nurses from "always" to "we are looking now for a nurse to start a health program"; 9 per cent had employed nurses from 40 to 75 years; 15 per cent for less than five years.

Nursing as seen in the Report of the Third National Conference on Health in Colleges. At the Third National Conference on Health in Colleges in 1947, a report was made on the nature of

As great a variation was found in the qualifications as in the ratios. In the colleges where their work was confined to bedside care, graduation from an accredited school of nursing and experience in private duty and institutional nursing seemed to have been all that was sought. In colleges where the nurse had teaching responsibilities and was used for advisory work with the students, two had bachelor's degrees, two had graduated from a school of education, some had had teaching experience in public schools or in schools of nursing, and the rest were taking additional courses in nursing or health education. The nurses in this second group all felt they needed still more work in nutrition, mental hygiene, and guidance and expected to continue to try to get it.

Dr. Rogers reported in 1937 on a study of college and university health services.⁽³⁾ From the summaries it is evident that nursing service was not limited to infirmary work. For instance, of the 106 coeducational institutions with registrations of 500 or less, only 50 reported infirmaries, but 64 employed nurses. Of the latter, 53 employed one nurse; 10 employed two; and 1 institution, three. Of 49 colleges with registration of 500-1000 students, 28 reported infirmaries, but 36 employed nurses. Of the latter, 25 employed one nurse; 9, two nurses; and 2, three nurses. Of 87 with still larger registrations, 49 reported infirmaries and 56 reported employment of nurses.

Of the 102 teachers' colleges reporting, 43 had infirmaries and 76 employed from one to three nurses. Ten of these were city institutions with students living in their own homes.

Surveys of college nursing in 1939 and 1949. Fern Goulding reported in 1939 on a survey of college nursing services in 67 colleges in five North Central states, made by a subcommittee of the School Nursing Section of the National Organization for Public Health Nursing.⁽⁴⁾ Fifty-five of these institutions reported the employment of nurses; a total of 116 were employed, 88 full time and 28 part time. All but 5 were professional registered nurses; 14 had bachelor's degrees, 4 were continuing with graduate study; 8 had had teaching experience; 25 had had some academic preparation in

Extension of college health services to include health supervision and services to faculty members and to other college employees requires additional nursing time.

As services of sanitary engineers are utilized in the program of campus sanitation and safety, the physician finds he can delegate to the nurse much of the follow-up to see that recommendations made by the sanitarian are carried out. Under his supervision the nurse also can do much of the interim checking needed between his visits, as the present-day nurse's preparation is well designed to enable her to carry specific limited responsibilities along these lines. Many of them relate not only to college administration but require cooperation with community agencies as well. A sanitary engineer who is a community rather than a college employee is often utilized for this service, and a public health nurse is accustomed to working with him.

In the well-developed college programs there is increased use of the nurse as an interpreter of health matters to students, faculty, and college employees to help them recognize and take steps to meet their own health needs. The nurse uses her knowledge of community health resources to guide to them the individuals who need their services. She screens students and staff when there is a question of communicable disease, and helps make immunization procedures available in the most effective, timesaving, and economical way possible. The physician has the nurse carry out technical treatment procedures, and she gives bedside care and supervises that provided by less well-prepared staff members.

As the general public has increased its understanding of what good health care involves, the demands of students and of parents of prospective students has stimulated colleges with inadequate or no health services to develop them. Expanding programs mean employment of more nurses. In colleges with no previous program, there is a tendency to employ a nurse as the first health service staff member.

The largest numerical increase in nurses employed by colleges probably results from those employed in "new" colleges. In 1952 the American Council on Education stated that in the preceding twenty-

college health programs in 300 colleges and universities in United States and Canada.⁽⁸⁾ The average ratio of nurses to students in all of these colleges was 1 to 530—in publicly controlled colleges, 1 to 660, and in the privately controlled, 1 to 470.

In 91, or 30 per cent of these institutions, a nurse who was employed was classified as a "campus public health nurse"; 33 of these were in the publicly controlled colleges (25 per cent of which employed such a nurse) and 58 were in privately controlled colleges (35 per cent of which employed such a nurse). Of these nurses, 47 apparently worked under the direction of college physicians in the 217 institutions which reported that the "student health service or dispensary" was the direct administrative responsibility of the college medical officer; but 44 of the institutions reported that the employee who had the direct administrative responsibility for this health service was the campus public health nurse.

The nurse as health counselor. Responsibility of college nurses for health counseling is seen to vary from the institutions where she has direct responsibility to those in which as infirmarian nurse she may not receive recognition for this function but always carries it nevertheless.

In 1951 Dr. N. S. Moore has described a specialized type of nurse counselor at Cornell.⁽⁹⁾ A nurse with unusual training is employed to integrate medical and general counseling services, her work sponsored by the dean of students office and the medical staff. The latter refer to her those problems which they consider due to academic or social causes, but which are causing physical symptoms because of emotional strain. The general counseling staff refer students with problems considered to be primarily medical.

Increasing use of nurses by colleges. Colleges with well-developed health programs find it necessary to make frequent changes in emphasis and activities in order to meet new problems which become evident in campus life and the changing needs of individual students. A recent trend in these "good" programs has been the increased use of the nurse's services, greater use of her abilities as an assistant to the physician, and additional direct responsibilities to her as a public health nurse.

and prevention of communicable disease. Not only are day colleges developing this type of service rather than aiming at a provision by the college of all the services needed by the college personnel, but many residential institutions located in metropolitan areas are utilizing community resources as much as possible for diagnosis and treatment rather than setting up or continuing to support duplicate facilities as part of the college plant. It is argued that not only is this plan more economical for the college and therefore for the student, but better service may be obtained. It is also believed to be better educational experience for the student to be directed toward obtaining service for himself, using resources which will continue to be available to him after he has finished his education. Development of hospitalization and medical care insurance plans has encouraged this trend.

Since the usual pattern for dispensary service is a part-time physician and full-time nurse or nurses, there has been a great increase in the number of nurses employed by colleges for this type of work.

Many of the increasing number of "day colleges" set up a dispensary as their only activity in health service. In such cases, the nurse may be made responsible for securing and reviewing the records of health examinations required as part of pre-entrance presentations, and for referring students for further examinations as indicated. She may also be designated to abstract from these records such information and recommendations as are pertinent to the supervision given by the physical education department, and also those needed for the counseling to be given him for personal adjustment or for vocational or educational guidance.

In this kind of a plan for health supervision, the nurse will probably be directly responsible for advising and directing the student until all the recommendations for treatment of defects or other health improvements have been carried out.

In the many small colleges throughout the country in which there has been no health service or other student personnel program, there is increased concern over this lack. In considering possible action along these lines, employment of a part-time physician and

four years, the number of accredited colleges and universities had increased from 399 to 904. When a public school system adds a junior college, it extends to it the health services provided for the other schools in its system, appropriately modified to suit the particular needs of the age group and the college organization. Characteristically a school system advanced in its thinking to the point where it assumes responsibility for a thirteenth and fourteenth year of public education, and wealthy enough to do so, has a well-developed health service. In the temporary colleges developed to meet the needs of the large number of returned veterans, the students were vocal in demanding health services for themselves and often for their families. The latter, especially, involves services the nurse is particularly suited to supply.

Another pressure for expansion of health services or their initiation where they are lacking has come with the movement for student personnel services in general. Development of any one phase of student personnel work points up to the college administration the need for health services at least sufficient to supply the information needed by student personnel staff members for understanding the students and giving them appropriate counseling along educational, vocational, or personal adjustment lines.

As students and their families, and college employees also, have become more knowledgeable of legal rights, administrators have recognized the economic advantage of instituting the comparatively inexpensive "dispensary type" of service. This not only provides a means for the college to meet its liability for health supervision of injuries which might be a basis for future law suits but results in shortening the duration of disability from other accidents and from illnesses, by early diagnosis and prompt medical care. Efficiency of students and employees is increased by reducing absenteeism and also preventing lowered production due to uncared-for illnesses and injuries. Convenient and liberal use of x-ray eliminates much uncertainty regarding the extent of injuries. The more easily accessible such consultative service is to students and employees, the more quickly they are apt to report early symptoms, reducing not only the period of their own disability but contributing to the control

better informed than the administrator. To him a "nurse is a nurse," and it may not occur to her that anything beyond bedside care will be expected of her.

A nonmedical administrator often asks such a nurse to carry responsibilities no nurse should be asked to carry. More frequently, however, the nurse is asked to carry functions which certain nurses might be able to do but for which she individually has not received the necessary preparation, although she may be exceedingly competent in more traditional lines of nursing service. It is essential that both nurse and administrator have a clear and common understanding of just what her responsibilities are to be. In such situations the advice of a disinterested agency may be utilized to consider these duties in the light of the nurse's general and professional education and in relation to her personality and experience. Such an agency is the Professional Guidance and Placement Service of the American Nurses' Association and many of its state associations.

The purpose of the following discussion is to outline some of the most usual situations and apply standards generally acceptable in other fields which might indicate the type of preparation and experience most helpful to the nurse in a college health service.

Health needs of students and of college employees which nurses serve. As in other areas of school nursing, the underlying purpose of the college nursing service is to help the student get and stay in the condition that will enable him to profit best from his educational opportunities and give him this assistance in such a way that the process itself will be of the greatest possible educational value to him. Health supervision and health services are extended to the teaching staff and other college employees both for the protection of the students with whom they come in contact and for the contribution to efficient management of the college.

Services in which the nurse may participate include:

1. Care when ill or injured
 - a. Usually limited to first aid and counseling in a day college
 - b. Often includes infirmary service in a residential college—medical treatment and bedside care

a full-time nurse often seems the most attractive possibility, as offering for the money to be spent the best answer to the greatest number of the problems being faced. The nurse may be asked to teach some health classes "with the physician taking over to discuss certain subjects with the men's groups." To avoid the impossible expense of setting up college treatment facilities the nurse may direct the students to the use of community facilities. She may be a liaison between the student body and a hospitalization insurance plan; she can assist the director of physical education in his health supervision of those engaging in strenuous athletics and be on hand for first-aid treatment during practice periods. For actual games a physician will usually be available, but the nurse will follow-up to see that injuries are properly cared for until recovery is complete.

There are, however, colleges whose only gesture toward any health supervision of their students is a requirement for a pre-entrance examination provided by the student's family physician. Some of these colleges are now employing nurses with public health backgrounds to review these records in order to see that any recommendations made are carried out by the college and by the student himself and to refer students if indicated, for further examinations, diagnosis, treatment, or continued supervision by their personal physicians.

Possible dangers to the nurse and to the college in rapid expansion. Although definite recommendations are available to the college administrator concerning the qualifications desirable for a college physician, a health educator, or a health counselor,⁽²⁾ none have been set up for the nurse who is to be employed for college work. An increased demand for nurses in the colleges at a time when there is a shortage of well-qualified nurses in many fields holds elements of danger as well as potentialities for good. Difficulties are reduced when the nurse is selected by a director of the college health service who is a full-time college physician as well. When nurses have been selected by nonmedical administrators, there have been many instances when too little attention was given to preparation to meet those responsibilities of college nursing which go beyond bedside nursing. The nurse chosen may be little

Care when ill or injured. In modern college life the phrases "report to the infirmary" or "see the nurse" are almost interchangeable, but it was not always so. Originally the infirmary was only a room or a group of rooms in which students were confined to remove them from contact with other students, or where those unable to go to meals were brought together in one place so their food could be brought to them with a minimum of bother. For anything further they had to depend upon the casual service of friends or servants, who perhaps had little skill in caring for the sick.

As a step forward, a "motherly person" was put in charge of the infirmary, and in addition to her original responsibility to see that they did stay out of contact with other students and that they did get fed, this person gradually assumed nursing duties as well. As a result today in the majority of instances the person in charge of the infirmary is expected to be a nurse. In some small service she may be a practical nurse, but usually she is a professional nurse.

The nurse in charge of an infirmary has all the responsibilities of the nurse in charge of a hospital of similar size plus certain definite responsibilities to students as an official of the college. She also acts *in loco parentis* for minor students in an emergency when parents or family physician cannot be reached. The qualifications for the nurse to be in charge of the infirmary, therefore, can be assumed to be equal at least to those set up for a nurse in charge of a hospital of similar size, plus some additional ones because of her special relationship to students and their families. The latter might be required of all nurses who are to work in the infirmary, not just the nurse in charge. Some college administrators consider it desirable to choose nurses who have had a college education prior to their nursing preparation in order that they have a more intimate understanding of college life and the problems the students face in it gained from their own personal experience. Whatever preparation for health counseling the infirmary nurse may possess, as part of her basic nursing education or as supplementary work following it, can be used to great advantage in utilizing the unusually susceptible condition of the students when they are ill to give them needed health guidance. Opportunities for such nurses to take addi-

- c. These services may be extended to faculty members, perhaps to all college employees
2. Continuous health counseling service
 - a. When sought by the student's or employee's own initiative
 - b. When special health supervision is indicated for certain individuals because of:
 - (1) Implications in the health history
 - (2) A handicap
 - (3) Special hazards in his educational or work program
 - (4) Engagement in competitive athletics
3. Protection against communicable disease
 - a. Administering such requirements as those for vaccination, chest x rays, and immunization against tetanus
 - b. Early attention to any deviations from normal possibly indicative of communicable conditions, prompt diagnosis, effective treatment, follow-up of contacts
 - c. Periodic inspection and continuous supervision of campus sanitation—food handlers, provision for food handling, fire prevention, swimming pools, dormitories, heating, lighting, and ventilation
4. Provision of a healthful emotional atmosphere which enables students and workers to live with a minimum of strain and to be stimulated to develop their health to its optimum possibility
 - a. Hygienic daily schedules of work, rest, and recreation
 - b. In selection of those staff members who will have close personal relationships with students and workers, consideration of personality characteristics most conducive to favorable emotional atmosphere
 - c. Establishment of college procedures facilitating a rapid adjustment, physically and emotionally, of those new to the college situation
5. Health education
 - a. Individual or group instruction given as health services are rendered
 - b. Instruction given in connection with health counseling (see 2 above)
(Classroom health instruction is not a part of "nursing services," though the nurse, if qualified, may engage in it)

specialist, to another college department, or to a community agency.

When there is no college physician, special effort should be made to secure a nurse who has had not only good preparation for health counseling but who has also had experience under good supervision in a comparable situation.

The nurse in communicable disease control. Increasing reliance upon the nurse for a larger part in the control of communicable disease in college situations has resulted from a number of factors:

1. Better preparation of nurses in general and especially for their special roles in communicable disease control
2. Present methods of communicable disease control emphasizing intensive supervision of apparently well people, early reporting of variations from normal, and early and effective isolation of suspects
3. Use of more part-time and less full-time medical personnel by college health services
4. Recognition that communicable disease control must be extended to faculty and all employees as well as students

As prevention and control measures, college programs usually feature: (1) use of the generally accepted protective measures, by students, faculty, and employees, such as vaccination against smallpox, immunization against diphtheria and tetanus, and in certain areas or for certain college activities, inoculation against typhoid; (2) tests—sometimes routine, sometimes as indicated by circumstances—to discover presence of or susceptibility to such diseases as tuberculosis, diphtheria, typhoid, syphilis, or gonorrhea; (3) immediate attention to any variation from normal, with effective isolation, prompt diagnosis, adequate treatment; (4) follow-up of contacts; and (5) review of the entire situation to determine causative factors and measures to prevent repetition.

The use of preventive procedures may be required or perhaps only encouraged by college policies. More generally than not, vaccination is required; the others are encouraged for all but may be required only for certain groups. In either case the nurse is generally the college officer who checks records to see if the requirements have been fulfilled and if not she instigates the necessary

tional courses in psychology, mental health, and teaching may be available to them in the college in which they are employed. Courses and special experience in first aid will also be useful. Experiences in hospital admission services, ward administration, hospital management, in planning, equipping, and supplying hospital facilities are assets to look for in selecting infirmiry nurses. Some of the courses set up to prepare nurses for industrial services are helpful. The personal qualifications would, of course, be those sought in all staff members who are to have a close personal relationship with students.

Public health nursing preparation and experience are of great value to the nurse who is to carry on a dispensary service as well as to the nurse working in any role in a day college where students and employees live in their own homes and use their own family health services. In a college where the only function of the nurse is to review and follow up the record of the pre-entrance examinations presented by the students, this preparation is vital. When the nurse is the entire health service staff the student himself must secure all the additional attention at expense and inconvenience much greater than when services are prepaid with his tuition and conveniently at hand. Only a high degree of skill and a great amount of specialized information will secure desired results in the way of supplementary examinations, diagnostic and treatment follow-up.

Continuous health supervision and health consultation service for students and employees. Easy and constant accessibility to health advisory service seems to be expected by students and employees and is being furnished by colleges in increasing amounts. In some institutions, medical service is sufficient so there is immediate access to a physician, with no preliminary screening. In others, there are one or more screening processes. For students, the first may be through a house mother, tutor, advisor, monitor, or other college officer who has a stated advisory responsibility for a small number of students. Through this person the student may be referred to the physician or to the nurse. In the case of an employee, his immediate supervisor may serve this purpose. The nurse may refer the individual to the college physician, family physician, a

involved. Tracing of contacts and dealing with problems revealed are activities for which the nurse has been specifically prepared. She will also have had experience in working with health department officials to analyze the causes and determine possible preventive measures. The nurse working in a college without a college physician carries on these activities under the direction of the health officer, otherwise, as with all of her work, under the college physician's direction.

Provision of healthful emotional atmosphere. As a nurse, she has definite help to offer in supervision of daily schedules of work, rest, and relaxation. She is prepared to participate in setting up policies governing the selection of staff members who will have close personal relationship with students. She can work with various college departments in developing projects to facilitate the adjustment of new students. Her point of view and her practical experience equip her to give cooperation of a unique value in general educational problems.

By early recognizing indications of emotional tension, she contributes to the preventive program by getting individuals needing special help immediately referred for it.

She has exceptional opportunities to use her ability to help people adjust to limitations imposed upon them by illness or injuries.

Environmental supervision. The amount of medical service and of supervision by a sanitary engineer which is available will lessen or increase the amount of responsibility given the nurse. If she is to be given unusual responsibilities, provisions should be made to ensure her preparation to meet them. Her basic nursing education can be expected to qualify her for certain but far from all phases of such supervision. She is equipped to participate in health supervision of food handlers, in securing hygienic maintenance of sleeping quarters. She is not necessarily ready to supervise mechanical dishwashers, fire prevention, swimming pools, heating and ventilation on a large scale nor for all aspects of proper lighting. It is true, however, that her nursing education has given her such a background that if there is no other college official already pre-

actions to secure them. For those which are advocated but not required she may have much more to do, as she must secure establishment of as many educational means as possible to develop interest and information concerning the value of obtaining immunizations. She will also have a part in securing and making known to all needing them provisions for obtaining the protections lacking.

When testing programs are put into effect in a college, in which there is not a full-time medical director, the nurse has considerable part in the planning, carrying out, and summarizing and using the results.

The nurse and the local health department. It is on the third measure—immediate attention to suspected presence of communicable disease—that the nurse who is working without a medical director works most closely with the local health officer.

In those college health services with adequate medical direction, it is in this particular part of the service where the nurse's help is most appreciated. When it is the nurse rather than the physician who is used for screening of those suspected, or suspecting the presence, of a communicable disease, or those who have observed some variation from normal and have no thought of a communicable condition, there are several factors which seem to stimulate an earlier reporting than when the screening is by the physician. For example, many people seem to find it easier to report to a nurse than to a physician, something which may turn out to be of no importance. Then too, the nurse is usually more easily accessible. Her other work brings her into casual contact with many people during the day, and they can report to her without making a definite effort to do so—at least without appearing to do so. Also her office is more often open for the entire school day than is the physician's. Even if he is a full-time college physician, his work is of such a nature that he is not always available while the nurse's office and work are planned for such interruptions. Making arrangements for isolation, diagnosis, and care are typical nurse activities, especially when the individuals concerned are members of families living off campus so that community relations and facilities are immediately

preparation for college health educators. This was modified from the qualifications for health educators set up by the American Public Health Association's Committee on Professional Education.

The nurse whose basic nursing education was obtained in a school of nursing rather than in a collegiate school of nursing may be disappointed when she finds how little of the required work she can be given credit for on the basis of her nursing education.

Preparation of the nurse for college nursing. It is obvious, from the foregoing description of the wide diffusion of nurses' activities in college situations, that it would be impractical for an institution preparing nurses for various types of employment to set up a program of study designed to prepare nurses for any and all types of college service. Rather an analysis should be made of what the responsibilities of the nurse are to be in a particular situation, by the administrator who is to select the nurse. This may be done in consultation with the present nurses, or if there has previously been no nurse employed, with the help of a consultant brought in for the purpose. A request to the Vocational and Guidance Service of the American Nurses' Association or to a similar service in his own state would bring him suggestions for locating such a consultant.

When the responsibilities of the proposed position have been decided upon, the position will probably be found to fall into one of the classifications listed below, or into a combination of two or more, or a combination of parts of several. The suggestions for the preparation for each of the types of positions have been received from nurses now or previously employed in college work, who on their own initiative secured such preparation after they were in their positions and found they needed help in the various areas.

1. Infirmary nurse who will work under close medical direction and nursing supervision

Minimum:

- a. Registered professional nurse
- b. Experience including outpatient department or clinic, admission service, first aid, etc.

Work with adolescent and postadolescent age group

pared for whatever supplementary environmental supervision must be carried by a staff member, she may be the one who can most easily be given the necessary preparation for it.

The nurse as a health teacher of individuals and as health consultant. In health education the nurse's unique opportunities for effective individual health instruction have long been recognized. College physicians and administrators are trying increasingly to correlate such instruction with the student's perception of his own health problem. Therefore, effort is made to have more nursing time available so the student may receive such instruction not only from the physician as the examination is made, but reinforcement by the nurse when indicated. There is also provision for her to use procedures set up by the college to help the student realize his need for carrying out all recommendations. When necessary the nurse helps him plan how to do so, and she does this in such a way that the experience will have the greatest possible educational value for him.

Properly prepared nurses have proven successful in group teaching also, and the larger number of nurses now available with the required educational backgrounds has resulted in their greater use in classroom teaching. In addition, nurses not directly responsible for classroom health instruction are used more frequently than formerly as "consultants" for such classes. One reason is that many present-day nurses are better equipped for this than were nurses previously. Another is the change in such classes from the lecture method to work which includes community projects and group discussions, in both of which the nurse has much to offer.

The nurse as a teacher of "health courses." Two essentials if the nurse is to have a chance to be successful in this function are:

1. She should meet the qualifications set up for health educators.
2. She should be allowed in her program an amount of time for any such teaching comparable to that allowed to other instructors. This means that her other duties should be reduced in due proportion.

In the Report of the Third National Conference on Health in Colleges will be found a description of minimum professional

years and college, that is between children of 6 and 16 than between 16 and 20.

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Desirable:

- c. Graduate of a collegiate school of nursing or two years of prenursing college work
 - d. Some postnursing school preparation in adolescent psychology, growth and development, and in counseling
2. Nurse in charge of the infirmary or working with a minimum of medical direction and with no nursing supervision
In addition to a, b, c, and d above:
- e. Experience in, or postnursing school courses to prepare for, ward administration and institutional management
3. Clinic nurse, to work under close medical direction and nursing supervision
In addition to a, b, c, and d under 1
- f. Further work along the lines described in d
 - g. Preparation for public health nursing to include some of the courses designed for industrial nursing
4. Nurse in charge of the clinic or working with a minimum of medical direction and no nursing supervision
In addition to a, b, c, d, e, f, and g
- h. At least a year's employment as 3
5. Health counselor
- i. Bachelor's degree to include or be supplemented by
 - j. Public health nursing preparation
 - k. Preparation for counseling comparable to that for other types of counselors

Application of general principles of public health and school nursing to college nursing. The college nurse will find these principles valuable to her. The problems of public and professional relations, the need for a study of her school and her community, the selection of her activities and construction of her schedule, her part in appraisal and screening processes, care of emergencies, recording and reporting, and working with students, families, and teachers, are subject to the same general principles used in dealing with pupils and school organizations of other age groups. In fact when it comes to methods of working, there must be greater differences between procedures used the first few years of the child's school experience and high school than between the high school

parents just as do all nurses, but, perhaps because of her easier accessibility, she may be appealed to more often than are some other nurses, by well-informed parents for elaboration or interpretation of something they have recently read concerning new developments in health, medicine, or education.

Another asset in her working situation is the nurse's own easier access to reliable sources of information—the professional people with whom she has daily contact and the school library. While it is unfortunate that school libraries too often lack in their faculty sections some of the desirable references on health subjects and health programs, the nurse may be pleasantly surprised to find how much is available in general reference volumes, such as encyclopedias, to one who has learned how to use them and who takes the trouble to do so. The more one knows about what one wishes to find, the more one can find. This gives an advantage to the nurse in using this source of information. The nurse who knows her faculty well appeals not only to teachers of special subjects as experts, but to those with particular hobbies. These enthusiasts are often found to have in addition to their personal information, volumes in their own libraries which go beyond those in the school or public library.

Through her participation in faculty discussion groups, informal as well as formal, the nurse builds up her store of information and accumulates leads for securing additional information when it may be needed, with a minimum of expense and effort.

She often has an opportunity to share in the in-service education programs arranged for teachers. She finds courses of specific value in such fields as those of psychology, sociology, and child growth and development, and of cultural and enjoyment value in such studies as those of history, English, foreign languages, and the arts.

Even if the school system employing the nurse is not among the small but growing number which offer sabbatical leaves for study, the nurse may find better opportunity for formal study periods than is offered to nurses in other fields of public health. She may have instead of the usual one month vacation the school's summer vacation, giving her opportunity for repeated attendance at summer

The Nurse's Activities for Personal and Professional Growth

The school situation offers certain stimulations to the nurse who works there. For the nurse employed by a board of education there may be a definite reduction in her exposures to some of the stimulations for development which are more available in the situations of nurses employed by other types of agencies.

Stimulations in the school situation. A nurse who responds to the incessant demand for "reasons why" propounded to an adult by children who discover a person willing to give serious consideration to their questions is supplied with motivation for continuous study in many and varied fields.

The nurse who discusses problems and plans with school administrators and teachers feels a constant need, not only to keep up on new scientific material in the health field but also on new types of thinking and developing philosophies. She will wish to do this quite completely in such fields as those of nursing, health, and social work, and at least to a certain extent in the field of education; the urge is strong to do this in order to maintain her status as a thinking and informed professional worker.

Parents offer stimulations to the nurse. She finds herself responsible for supplying sound basic health information to uninformed

this group also. Employment in a resident camp for school age children is especially valuable in giving the nurse firsthand experience in dealing with the 24-hour-a-day problems which parents must meet.

Retarding factors which may occur in the school situation. There are fewer financial assistance plans available for the nurse preparing for school work than for those preparing for generalized public health nursing or for such other specialties as tuberculosis, mental hygiene, or venereal disease nursing.

The overconfidence which some school authorities feel in the nurse "just as she is" may be a factor inhibiting the nurse's desire or even her freedom to further improve her nursing ability through attendance at nursing meetings or by additional nursing education. It may also stand in the way of development of adequate supervisory service.

It is because a school nurse IS a nurse that she is valuable to a school. As a single nurse in a large group of non-nurse workers, her most appreciated contributions result because of her differences from the teachers not because of her similarities to them. Nevertheless to a greater extent than other nurses those employed by boards of education often must depend on their own initiative and expense to secure many of the experiences designed to improve their nursing development. Both Dr. Kilander's study and the census of public health nurses made annually by the United States Public Health Service (see Chapter 5) show less supervisory service for nurses employed by boards of education than for those employed by other agencies.

While the nurse's attendance at certain educational meetings may be facilitated once or twice a year by the closing of schools for them, her attendance at nursing and health meetings may be difficult to arrange when they are held during school sessions. For the nurse who has begun her school employment before completing her field experience in public health nursing, there may be difficulty in obtaining a leave of absence for the period required. This field experience is especially important for the nurse in school work to have as it is fundamental in preparing her for that part

sessions of a college or university. This possibility for continuing her education seems to have been, indirectly, responsible for much of the success of the school nursing program, contributing to the raising of qualifications for school employment, and these in turn have resulted in the establishment of desirable salary schedules—both of which have been factors in attracting superior nurses into the field of work. This is how it has happened: an energetic, ambitious, professionally minded nurse was attracted originally to this specialty although the salary might have been lower than she might have obtained elsewhere and the current qualification requirements were lower than those she had to offer, because she found here the best opportunity to continue her education. Often she planned to continue in this field for only a specified number of years, until she had obtained the amount of education outlined. During this time, however, it often happened that because of her demonstration of unusual contributions such a nurse as she was could make, the status of the school nursing position in that school was changed; the requirements for it were changed from the previous one of "R.N." only, to those of the nurse now in the position, with a salary comparable to what such a nurse would receive in other fields. In many instances, the nurse stayed on in the position after she had completed her college work: when she did leave replacement was sought among candidates of a similar level.

In a school setting the nurse who has "completed her education" is encouraged to return periodically for further work and to continue participation in extension courses. This may be because of her discovery of pleasure in study, the example of her school teacher friends, recognition of additional work by an extra increment on the salary schedule, or in a few instances because of a mandate in the certification requirements.

Surveys in several states have indicated that slightly more than half of the nurses receiving school vacations avail themselves of the opportunity to keep up their nursing skills and to learn new nursing procedures, as well as to add to their incomes by returning to hospital employment for regular or irregular periods each year. A considerable proportion of camp nursing positions are filled from

of her services most valued by the school—for the services most different from those teachers are equipped to give.

Practical possibilities. To all nurses, even those most isolated or restricted financially, there are three resources for professional growth, provided the nurse possesses the determination to use them: professional literature, learning from the people around her, and learning from her own experience. This last requires the greatest effort and most careful attention; it is by no means automatic.

Professional reading. To utilize professional literature requires a definite budgeting of time and money for the purpose; the first must be considerable, the latter may vary from a minimum to any amount. Initiative and planning are also necessary. A few pennies for postage, to place her name with her school address on the mailing lists of all state and national agencies furnishing material relating to children, health, or welfare will start a steady flow of pertinent material to her. Payment of postal charges for the loan of books and reference magazines (at reduced book rates) will secure library services for her.

The nurse must provide herself with some way of learning about new publications as they become available. A joint subscription with teachers to an educational magazine, a joint subscription with other nurses to the *American Journal of Nursing* to supplement her own subscriptions to *Nursing Outlook*, and the *Journal of the American School Health Association* will provide these leads on a minimum budget. They will include, besides the many articles of value to her, book reviews and announcements of professional publications.

As she reads, additional references are brought to her attention. Single copies of many pamphlets on professional subjects are available, free to professional workers or to educational institutions.

Learning from those around her. The nurse with an inquiring mind can learn a great deal from the successes and failures of those around her, in their dealings with her and in their dealings with one another. She can learn from mothers not only the information they give her about their children but much concerning successful and unsuccessful methods of dealing with children. Especially

valuable are her observations of an intelligent mother of a large family as she applies with the younger children what her experience with the older ones taught her.

Another fertile field for the observant nurse is comparison of results obtained by the different teachers and discussing outcomes with these specialists in child management. The nurse may draw some conclusions from the way the administrator deals with children, parents, teachers, and with the nurse herself, for he is a specialist in human relations.

From the physicians with whom she works—school physician, health officer, and family physician—there is no limit to what she may learn: information about children, approved procedures, and methods of work.

In her fellow nurses, she has one of the best sources of learning. When her professional reading can be followed by a discussion of it with another nurse or a group of nurses, it will mean much more to her. It is seldom that it is impossible for a nurse to be a part of at least two professional groups for planning and discussion: with the teachers of her area and with other nurses. Even when she is the only public health nurse there are other nurses of some variety. It is important for her to join with at least these two local groups, as limitation of personal participation to an occasional state or national meeting is insufficient to meet an individual's need for personal participation.

Perhaps partly at least because of the lack of supervisory help, school nurses have been particularly active in organizing themselves into county groups. These vary from quite formal to a very informal type of organization, with a wide range of activities which vary greatly from county to county as well as from state to state.

In counties with a superabundance of organizations the school nurses' group may confine itself to two functions: to see that the school nurse point of view is represented in all county projects where it has a value and to arrange for senior advisors for nurses new in the schools.

In other counties it may function much more intensively and include such projects as: program meetings on pertinent topics;

development of in-service extension courses, workshops, or institutes in the fields of nursing or health education; arrangement of joint meetings to discuss mutual interests with other professional groups in related fields such as other public health nursing groups, dental hygienists, and audiometer technicians, health teachers, attendance supervisors, welfare workers, staffs of children's courts, etc.

Some groups meet monthly, others as infrequently as twice a year. On occasion, the nurse's group joins with another group of professional workers or citizens to work to obtain or to improve local facilities for the health, education, or welfare of the children of the county.

The complexity of our social organization has become such that no one nurse can possibly attend all professional meetings in which she has an interest unless she is in a most isolated situation. Therefore some county groups arrange that representative members attend certain meetings and report back to the group concerning them.

Some such groups have combined their county meetings with school visiting days. Succeeding meetings are held in different schools until all have been visited. A tour of the buildings and grounds is followed by a discussion of the school's program, participated in by the school physician and administrator.

Then the regular program or business meeting is held. There are two hostesses for each meeting so that the presiding chairman may be free from interruptions—one the nurse of the host school and the other to preside at the meeting. Rotation of responsibilities is a feature of management of the group so it may serve as a training center to develop leadership abilities in each member. Assignments are usually made to a team of two or more, rather than to a single individual, in order to develop team work, to ensure against emergencies and to focus attention on the project rather than on the person doing or reporting it.

Each spring members of the group send to the secretary information about expected changes of nursing personnel for the coming year and the group carries out whatever plan has been decided upon for the appointment of senior advisors for the new nurses

expected the next fall. In some counties there is a counseling committee; in others an individual advisor is appointed for each new nurse. New nurses value this plan for many reasons. It puts them in immediate contact with their professional group. It helps compensate for the all too usual inadequacy of supervisory service. By giving them an immediate and easily available source of information concerning local resources it increases their efficiency in getting work under way in a new situation.

Learning from her own experience. The possibility of learning from experience is always present but the ability or the desire to do so may be lacking. Here is one of the many situations in school nursing where the help of a supervisor is of vital importance. Real skill is required for self-evaluation, and most of us need help in acquiring the objectivity which must underlie it.

Measuring one's accomplishments against objectives set is one way to learn from experience. Measurement against accomplishments of others in somewhat similar situations is another possibility.

The nurse who is secure enough within herself so that she can not only take but can actually welcome criticism has another resource; she can ask certain selected people with whom she works to help her analyze causes of failure to accomplish what she set out to do.

Participation in professional organizations. There are many professional fields in which nurses doing school work have an interest—medicine, public health, school nursing, and other areas of public health nursing, parent education, social work, and of course general education. It is a real problem for her to choose to which of the many fine organizations, soliciting for her membership and active support, she should give her time and money.

She realizes, though perhaps not to the full extent, how the programs of nursing, public health nursing, school nursing, health education, and health services have been facilitated because of the well-directed efforts of such organized groups. They have helped obtain favorable legislation both for the programs involved and for the workers who carry out the programs. The three professional groups of the most fundamental importance to the work of the

nurse in the school are those of nursing, public health nursing, and education.

American Nurses' Association. Whatever the previous area the nurse may have been working in before she came into school nursing, she was probably a member of her district, state, and national nurses' association and through the American Nurses' Association a member of the International Nurses' Association. She will wish to continue this membership with perhaps a change of section.

Her ability to participate effectively in this organization's work which deals with the functions, qualifications, and personnel policies for nurses may have been increased by the preparation obtained for school nursing and by the experiences she is having in her daily activities. She has more opportunities than do nurses in some other lines of work to learn leadership and followership, how to conduct meetings, how to participate in meetings, and how to do effective committee work as chairman or as a committee member. In a number of states there are state school nurses' organizations. Some of these function as sections of the state nurses' association.

League for Nursing—national and state. The nurse engaged in school work finds many reasons for belonging to this organization and participating in its activities. Its program for improving nursing services is of immediate concern to her. With a membership made up of both nurses and the consumers of nursing service, the general public including boards of education, parent groups, and individuals interested in children, health promotion, or schools, the nurse finds that an opportunity is open to work most effectively for the improvement of school nursing services as part of all community nursing service. The School Nursing Section of the National Organization for Public Health Nursing, organized in 1920, was one of the first special interest groups to be organized.

NLN's program to improve nursing education is another matter in which the school nurse has both a personal and a professional interest. She has ideas concerning the preparation which she thinks would be most valuable for nurses to have in order to do school

nursing better, and she appreciates a chance to participate in making plans to provide the best preparation possible.

A possible contribution of the school nurse to NLN's program to improve basic nursing education. The nurse is motivated to desire to help in this field because of her realization of the value to students of nursing there would be in providing them with an opportunity to study well children in the school situation. There is a steadily increasing emphasis in the teaching of pediatrics on the need for the student to know the well child not only as a basis for study of the care of the sick child but to enable her to function in health development. Along with the increase in numbers of nursing students there has been a great decrease in the hospitalization of children, making it difficult to give students sufficient experience with children. There is also the increasing emphasis on the need to teach nursing students about health as well as disease. The contribution which used to be asked of the school nurse was to give an hour lecture to the senior class describing her school program to them.

In some areas this has been replaced by a request that she participate in a plan to give all students opportunity to observe and study well children in their normal activities. Besides contributing to the student's development as a nurse for health, this understanding of well children gives her a background for learning to understand them in the hospital when they are ill. Her observation periods with the nurse as she performs her school duties are not designed to prepare the student for "school nursing" but rather to let her become familiar with other institutions besides her hospital which are concerned with health—the school itself and the community agencies with which the school nurse works. It also gives the student a chance to see the child as a member of the family, and to see the family in its relationship to the community. When she returns to the hospital this may help her to see the adult patient as a personality, as an individual, and as a member of the community also.

The nurse gives the student opportunities to see the application

of principles of teaching in her interviews with pupils, parents, and teachers; to see techniques used to develop rapport with the child and family. She may be able to help the student see possibilities for applying these to her own work within the hospital.

Probably less than 1 or 2 per cent of such students will later prepare themselves for school nursing, but there will be a real advantage to school health programs in general if those students who later enter other fields of nursing have a good understanding of the purpose and the program of school health service. There may be even greater advantage if those who leave nursing and become mothers have this understanding.

There are certain decisions which must be made if a plan for giving such experience to students of nursing is to be successful:

1. How much time is to be allowed the student for this experience?
Will it be all in one period or at spaced intervals?
At what stage or stages in her course will it come?
Will it be with one school nurse, with several, or with another public health nurse also?
2. What does the director of the nursing course expect the student to get from this experience?
3. What does the school nurse expect to be able to give her?
Are her school administrators and teachers also interested in the project? Do they expect to participate in it?
4. Will opportunity be given for the school nurse to meet with the director of nursing education to make definite plans for:
 - Time assignments
 - Reference readings for the student
 - Coordination with the student's subject matter courses
 - Outline of the student's report on her experience
 - School nurse's attendance at a conference at which the experience which students had with the nurse (and with other public health nurses) are discussed by students and their instructor. This gives the nurse a chance to clarify misconceptions and to plan improvements in the experiences to be given to following students.

If it is decided that the assignment is to be limited to one, two, or three days, as much as possible of the time should be spent on

home calls as school observation would be too limited to be of much value.

If more than three days is allowed, emphasis should still be on home calls but in addition some of the following may be included:

- Observation of normal children at
 - Kindergarten age
 - Third or fourth grade
 - Junior high school
 - Senior high school

Students are sent to such groups containing pupils with observable defects such as mouth breathing, malocclusion, poor posture, fatigue, nervous tension, tics, malnutrition, etc., and encouraged to note these variations from normal.

Students are asked to comment favorably and unfavorably on features indicating hygiene of the child's school day, and to suggest adjustments at school or home which might help compensate for unfavorable factors.

They are asked to note items in the child's school environment which are superior in hygiene to the environment he is in when hospitalized, and those inferior to it. What modifications might be desirable?

If time is sufficient to allow the student to observe general health services, she can compare activities, purposes, and results of the school health service with those of the hospital. Emphasis is on the student's becoming acquainted with normal children rather than on participation in evaluation of the health service.

Selection of the home visits to be made by the student nurse with the school nurse is done with care. When possible the selection is of a family with recent hospital experience and one with which the student has had no personal social contacts.

A situation is selected where health teaching to the family rather than a mere obtaining of information from the family is the reason for the visit. When it can be arranged the student is allowed to participate in several visits to the same family should long-range planning be needed. If several families can be visited they are chosen from varied social and economic groups.

The visit is designed to give the student an increasing appreciation of the hospital patient as an individual, as a member of the family and of the community. It may be used to illustrate:

1. Individual teaching which the student has to learn to do as she gives care in the hospital.
2. Establishing rapport with the patient by the nurse. The student must do this with each of her patients.
3. Considering special needs of an individual or a family. The student needs experience in applying to specific situations general principles taught to her in her classes.
4. Interview to obtain information. Such interviewing is a frequent duty of the student nurse in the hospital.
5. The health agency (the school health service) and its methods of work, differing from and similar to the hospital and its methods.
6. The family and how it is affected by illnesses or health problems of its members.

Conferences of school nurse and student nurse both before and after the visit are important. The nurse reviews with the student, noting particularly hospital and community relationships, Part I of "Data Involved in Planning and Reporting a Home Visit." (See page 348.) She arranges for the student to observe the pupil concerning whose problems the visit is to be made and also his siblings. She considers the possible advantages of not discussing family attitudes and peculiarities with the student until *after* the visit, but rather to ask her for *her* impression and what her observation of the children leads her to expect to find in the home. After the visit, Parts II, III, IV (of data outline, page 349) are reviewed, and the student is allowed to participate in the referral process if possible.

There is a review of the preventive health measures of which the family has had the benefit (or if not, why not?); of community resources with which the family has had contact; of the needs for which community resources are lacking. There is a summary of the questions concerning the family which are still unanswered but concerning which information should be obtained when better opportunity offers.

There is a discussion of the status of the special problems for

which the visit was made; of other health problems; plans for future work with the family.

Among the items which might be included in the report of the student on the home visit are:

If hospitalization should become necessary for a member of this family what problems might develop? If it were the mother? The father? The child? (There should be included emotional, mental hygiene, economic, family management, transportation, distance, religious problems.)

What possibility does the student see of a hospital nurse helping to meet such problems in this particular case?

In relation to the health problem for which this call was made, does the student think that the parent appreciated the existence of the problem? Before the call? As a result of the discussion? Does the student think the parent expects to take suitable action?

Did she observe the school nurse using any methods of developing rapport or of teaching which the student could use while giving bedside care? What changes, if any, would be needed to make this home an ideal one in which to develop healthy children, socially, emotionally, and physically? Are these changes possible? If not what changes in the community or in society would be necessary?

A possible contribution of the school nurse to NLN's program to improve the education of public health nurses. A study made by the Collegiate Council on Nursing Education* showed a definite lack of experience in the school setting given in most of the institutions preparing public health nurses. When it has been given, it has proven of value for nurses who entered positions which did not include school services as well as for those which did though in a different way. A nurse employed by a health department is able to cooperate more effectively with the school staff on such matters as communicable disease control, orthopedics, nutrition problems, rehabilitation, and parent education, when she is more fully informed concerning the varied resources of the school program.

Nurses who have had this experience after they had served as industrial nurses regretted that they had not had it previously, as

* National Organization for Public Health Nursing: *Preparing the Public Health Nurse for Work with School Children*. Mimeographed. The Organization, New York, June 27, 1949. 5 pp.

they found they could be more helpful in advising the many employees who came to them with problems which involved their children after they understood children better, and when they had more concrete information to give regarding the help parents might obtain from the school health service and through the school program in general.

Nurses experienced in general public health nursing have sometimes been surprised to learn of the help which school facilities could have given them in their previous positions but of which they were uninformed at the time. Such nurses are impressed by the accuracy and extent of the school records, including those on health, by the potential strength of the teacher-pupil-parent-nurse team and by the extent to which health projects radiate from the school into the home and the community.

A nurse who goes into any type of community nursing without a recent school experience many times makes the mistake of assuming that the school program including its health service is what it was when she attended school. Not only was the picture she gained as a pupil incomplete and biased by her particular needs, but the program and philosophy have changed, perhaps radically, since her childhood.

In preparation for the supervision of school experience of public health nursing students by school nurses, university staff members, supervisors of school nurses, and carefully selected school nurses in the university area meet together to work out very definite plans for the experience which is to be offered. The matter is explained to, and discussed with, each school administrator concerned and his approval obtained before the nurse accepts an invitation to participate.

Immediately preceding assignment of students to the school nurses another conference is held which includes the students as well. Details of arrangements are discussed here. There is group discussion of general problems which may be encountered. The student meets the nurse under whom she is to have the experience. Students have an opportunity to state what they hope to get out

of it. Explanations may be necessary as to why some of these expectations may not be realized.

To facilitate recording and reporting the experience obtained by the student, a blank is supplied which contains a great many more items than can be included in any one student's experience. (This blank is drawn up by the participating school nurses and representatives of the university staff.) At the close of each day the student checks on it the activities she observed, participated in, or carried on that day. The school nurse reviews the entries. At the close of the period each signs it and the school nurse sends it to the university with her evaluation of the student.

Following the experience period a final conference of students, school nurses, and faculty members gives opportunity to analyze some situations which were especially significant, quite typical, or unusual. Reactions of the students are utilized in modifying plans for improving future experiences.

Giving such experience to a student is a real contribution from the profession of school nursing to the preparation of a new nurse for school health service. One reason for the too frequent lack of such experience as a part of the preparation of a public health nurse has been the difficulty in arranging for it. Careful planning such as is outlined above has been found to eliminate many of the difficulties previously encountered.

Supervising a public health nursing student is a stimulating experience for a school nurse if she can feel she is doing an adequate job. As she participates in the preliminary planning conferences she evaluates her own program and learns to be objective in her analysis of its weaknesses as well as its strengths. Impersonally, plans are made when necessary to supplement her program with other opportunities for the student.

This period of working with the student nurse becomes a time of intensive self-supervision as the school nurse becomes more conscious of each procedure, relationship, and reaction. She sees her work in a new perspective. The intensive advisory relationship she develops with the student increases her interest and ability

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in the vocational guidance she gives high school pupils concerning their choice of nursing as a career.

When it functions properly the supervisory period is a cooperative form of education. The school nurse is interested in new scientific data the student may have received in her recent university courses, and in the new public health nursing trends or techniques that she may bring with her from her other field work experiences.

The school nurse and professional educational organizations. The nurse employed by a board of education is usually a member of her local teachers' group and of the state teachers' association. She is usually invited to belong to the National Education Association and particularly its American Association for Health, Physical Education and Recreation.

The school nurse and school health organizations. A large proportion of the membership of the American School Health Association is made up of nurses in school work, who are represented among its officers and contribute frequent papers to its *Journal of School Health*. A growing number of nurses are found in the membership of the School Health Section of the American Public Health Association and working on its committees. Others choose to belong to the Public Health Nursing Section of the APHA.

The problem of expense. Few nurses can afford the time or money to participate in the work of all the professional organizations which attract their interest. Careful choices must be made. Inclusion of a definite amount of money in her budget allocated to memberships fees, professional literature, and for travel to meetings is a first step. For a nurse on a beginning salary 2 or 3 per cent of her income may be as much as she may feel she can afford. As her salary rises above a subsistence level she may be able to increase it to between 5 and 10 per cent depending on her circumstances.

Time must be budgeted in a comparable manner. There may be some organizations to which she can give only financial support. She may use a rotation plan in choosing the organizations to which she will give time—participating one year in a certain one where there is a project developing in which she has a particular interest,

and when her work on that is finished accept an assignment with another group another year. For her own emotional satisfaction she will want to do continuous work in one or two of special concern to her.

Attendance at professional meetings during school sessions. School administrators who appreciate their nurse's participation in professional activities can encourage her to be active in them by cooperating with her in the arrangement of her schedule so that she may attend important meetings, at whatever time they may occur. This does not mean "excusing the nurse from her work." By its very nature her work requires her to follow hours other than those of the school schedule. There are some parents who can be interviewed only in the evening or on a week end. Often an emergency will require her to work until a certain situation is under control. Though a school may have a policy of not excusing classroom teachers to attend meetings during school hours, the school nurse's situation is different. Some of the meetings most essential for the nurse to attend are with nonschool groups which cannot observe school restrictions in setting their meeting hours. It is at such meetings that the school nurse is most apt to receive help on problems which, by their nature, are such that she did not receive preparation for them in her preservice education—problems not in the nursing field but in her particular situation with which she is required to cope. In other instances they are newly developing problems. She is working in such a highly specialized field that a maximum of technical guidance is required. A report, oral or written, is submitted for each meeting attended on "school time."

In handling new problems she may well be the liaison officer between technical groups and the school and again between the school and parents. The startling speed with which health problems can develop may require emergency changes in accepted procedures. The school nurse's schedule must be kept flexible enough to allow her to meet these situations as they arise.

To the nurse may fall a considerable portion of the activities involved in coordinating school health service into community life, which involves attendance at meetings, participation in committee

ADDRESSES OF ORGANIZATIONS AND MAGAZINES

Accrediting Service of the National League for Nursing, 2 Park Ave., New York 16, N. Y.

American Academy of Pediatrics, 638 Church St., Evanston, Ill.

American Association for Gifted Children, Inc., 15 Gramercy Park, New York 3, N. Y.

American Cancer Society, Inc., 47 Beaver St., New York 4, N. Y. State and local societies.

American College Health Association, changes address with officers. Regional and state associations.

Magazine: none; the *Journal Lancet*, published by the Lancet Press, Minneapolis, Minn., serves as an outlet for news and for available publications.

American Council on Education, 744 Jackson Place, N.W., Washington, D.C.

Magazine: *Educational Record*, same address.

American Dental Association, 222 East Superior St., Chicago 11, Ill. State and local associations.

American Diabetes Association, 11 West 42nd St., New York 18, N. Y.

Magazine: *Forecast*, same address.

American Hearing Society, 817 14th St., N.W., Washington 5, D.C.

State and local societies.

Magazine: *Hearing News*, same address.

American Heart Association, 1775 Broadway, New York 19, N. Y. State and local associations.

American Home Economics Association, 1600 20th St., Washington 9, D.C.

American Medical Association, 535 North Dearborn St., Chicago 11, Ill. State and local associations.

Bureau of: Health Education of the American Medical Association.

Magazines: *Journal of the American Medical Association*, same address. *Today's Health*, same address.

American National Red Cross, 17th and D Streets, N.W., Washington 13, D.C. State and local chapters.

American Nurses' Association, 2 Park Ave., New York 16, N. Y. State and district associations.

ANA Professional Counseling and Placement Service. State offices.
Magazine: *American Journal of Nursing*, same address.

American Psychiatric Association, 1270 Sixth Avenue, New York 20, N. Y.

American Public Health Association, Inc., 1790 Broadway, New York 19, N. Y. State and local associations.

Magazines: *American Journal of Public Health*, same address.
Nation's Health, same address.

American School Health Association, 3335 Main St., Buffalo, N. Y. State and regional associations.

Magazine: *Journal of School Health*, same address.

American Social Hygiene Association, 1790 Broadway, New York 19, N. Y.

Magazine: *Journal of Social Hygiene*, same address.

American Speech and Hearing Association, Wayne University, Detroit, Mich.

Magazine: *The Journal of Speech and Hearing Disorders*, same address.

Association for Childhood Education, International, 1200 15th St., N.W., Washington 5, D.C.

Magazine: *Childhood Education*, same address.

Boy Scouts of America, 2 Park Ave., New York 16, N. Y.

Bristol-Meyers, Educational Service Department, 45 Rockefeller Plaza, New York 20, N. Y.

Camp Fire Girls, Inc., 16 East 46th St., New York 17, N. Y.

Child Study Association of America, 132 East 74th St., New York 21, N. Y.

Magazine: *Child Study*, same address.

Children's Bureau, Federal Security Agency, Washington 25, D.C.

Magazine: *The Child*, Superintendent of Documents, Government Printing Office, Washington 25, D.C.

Cleanliness Institute, 295 Madison Ave., New York, N. Y.

- Cleveland Health Museum, 8911 Euclid Ave., Cleveland 6, Ohio.
- Committee on Careers in Nursing, National League for Nursing, 2 Park Ave., New York 16, N. Y.
- Derbac Service, Education Department, 334 East 27th St., New York, N. Y.
- Food and Nutrition Board of the National Research Council, Washington 25, D.C.
- General Federation of Women's Clubs, 1734 N. St., N.W., Washington, D.C.
- Girl Scouts of the USA, 155 East 44th St., New York 17, N. Y.
- Illuminating Engineering Society, 51 Madison Ave., New York 10, N. Y.
- Institute for the Crippled and Disabled, 400 First Ave., New York 10, N. Y.
- League for the Hard of Hearing, 480 Lexington Ave., New York, N. Y.
- Maternity Center Association, 654 Madison Ave., New York 21, N. Y.
Magazine: *Briefs*, same address.
- Metropolitan Life Insurance Company, Health and Welfare, 1 Madison Ave., New York 10, N. Y.
- National Association for Mental Health, 1790 Broadway, New York 19, N. Y.
Magazine: *Understanding the Child*, same address.
- National Association for Nursery Education, care of Roosevelt College, 430 South Michigan Ave., Chicago, Ill.
- National Bureau Casualty and Surety Underwriters, School Safety Division, 1 Park Ave., New York 16, N. Y.
- National Catholic Welfare Conference, 1312 Massachusetts Ave., N.W., Washington, D.C.
- National Congress of Parents and Teachers, 600 South Michigan Blvd., Chicago 5, Ill.
Magazine: *National Parent-Teacher*, same address.
- National Council of Catholic Nurses of the U.S.A., 1312 Massachusetts Ave., N.W., Washington, D.C.
Magazine: *Catholic Nurse*, 120 Boylston St., Boston 16, Mass.

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National Dairy Council, 111 North Canal St., Chicago 6, Ill.

National Education Association, 1201 16th St., N.W., Washington 6, D.C.

Magazine: *Journal of the National Education Association*, same address.

Departments of the NEA, same address:

Adult Education.

American Association for Health, Physical Education and Recreation.

Magazine: *American Association for Health, Physical Education and Recreation Journal*.

American Association of Colleges for Teacher Education.

American Association of School Administrators.

Elementary School Principals.

Home Economics.

International Council for Exceptional Children.

Magazine: *Exceptional Children*.

National Association of Secondary Principals.

National Council of Administrative Women in Education.

Rural Education.

National Epilepsy League, 130 North Wells St., Chicago 6, Ill.

National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y.

National Health Council, 1790 Broadway, New York 19, N. Y.

National Jewish Welfare Board, Inc., 145 East 32nd St., New York, N. Y.

National League for Nursing, 2 Park Ave., New York 16, N. Y. State and local leagues.

Magazine: *Nursing Outlook*, same address.

National Publicity Council for Health and Welfare Services, Inc., 257 4th Ave., New York 10, N. Y.

National Safety Council, 425 North Michigan Ave., Chicago 11, Ill.

Magazines: *Safety Education*, same address.

Public Safety, same address.

National Society for Crippled Children and Adults, 11 South LaSalle St., Chicago 3, Ill.

Magazine: *Crippled Child*, same address.

National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y. State and local societies.

Magazine: *Sight Saving Review*, same address.

National Tuberculosis Association, 1790 Broadway, New York 19, N. Y.
State and local associations.

New York Heart Association, 2 East 103rd St., New York 29, N. Y.

Nursing Advisory Services for Orthopedics and Poliomyelitis, NLN and NFIP, 2 Park Ave., New York 16, N. Y.

Office of Education, Federal Security Agency, Washington 25, D.C.

Magazine: *School Life*, Superintendent of Documents, Government Printing Office, Washington 25, D.C.

Public Affairs Committee, Inc., 22 East 38th St., New York, N. Y.

Public Health Service, Federal Security Agency, Washington 25, D.C.

Magazine: *Public Health Reports*, Superintendent of Documents, Government Printing Office, Washington 25, D.C.

Traffic Engineering and Safety Department, American Automobile Association, Washington, D.C.

Tuberculosis Nursing Advisory Service, NLN and NTA, 2 Park Ave., New York 16, N. Y.

Volta Bureau, 1537 35th St., N.W., Washington, D.C.

Magazine: *Volta Review*, same address.

Additional nursing magazines:

Nursing Research, 2 Park Ave., New York 16, N. Y.

Nursing World, 468 4th Ave., New York 16, N. Y.

R. N., 210 Orchard St., East Rutherford, N. J.

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